MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 715 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Ackerman

4. DATE OF DEATH: (Month) 1 (Day) 18 (Year) 19 50

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: 2/9/85

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Inspector

10b. KIND OF BUSINESS OR INDUSTRY: W. Md Ry.

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Joseph Ackerman

14. MOTHER'S MAIDEN NAME: Barbara Richard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-4754

17. INFORMANT AND ADDRESS: Mrs Caroline Lippold - Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Pancreatitis — Interval Between Onset and Death: 5 days

587.0

Antecedent cause(s)

128

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Jan 18, 1950, that I last saw the deceased alive on Jan 17, 1950, and that death occurred at 4:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. Jan. 18, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan 20, '50 — NAME OF CEMETERY OR CREMATORY: St Peter & Paul Cem. — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Jan. 19, 1950 — REGISTRAR'S SIGNATURE: Wister R. Frantz M.D. — FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland Md

318-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1950
BUREAU OF S.

Within corporate limits

00002

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 8 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Spring Gap (rural)
STREET ADDRESS (If rural give location): Rt. 4, Cumberland, Md.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John		Adams 3rd.	Jan.	11	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	single	Aug. 22-1948	1 yrs.	4			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Md.	U.S.

13. FATHER'S NAME: John Adams Jr.
14. MOTHER'S MAIDEN NAME: Mary Jane Ritchie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

916.0 **Immediate cause** (a) 2nd. & 3rd. Degree burns (extensive) — INTERVAL BETWEEN ONSET AND DEATH: about 9 hours.

180 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) of face, neck & hands.

(c) Bronchial burns due to inhalation of fire.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒* OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	home	Spring Gap	Allegany	Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☒*	HOW DID INJURY OCCUR?
about 8 Jan. 11/50 A m.		House caught fire, & child was burned

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	Jan. 12-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 15, 1950	Mt. Tabor Cemetery	Allegany Co.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 13, 1950	Wynter K. Frantz, M.D.	John J. Hafer	Cumberland, Md.

XVX99

VS-A15A

RECEIVED
JAN 17 1950
BUREAU V. S.

Within corporate limits

00003

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 87 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 306 Pulaski St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 306 Pulaski St.

3. NAME OF DECEASED (Type or Print): (First) Henry; (Middle) A.; (Last) Appel

4. DATE OF DEATH: (Month) Jan; (Day) 16; (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 21 1862

9. AGE last birthday: 87 yrs. If under 1 year: Months —; Days —; If under 24 hrs.: Hours —; Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass worker: Retired

10b. KIND OF BUSINESS OR INDUSTRY: Glass.

11. BIRTHPLACE (State or foreign country): Cumberland Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Appel

14. MOTHER'S MAIDEN NAME: Christian

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: Mrs Luther Appel, Cumb'd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic myocarditis — Interval between onset and death: 5 yrs

422.1

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 15 yrs

93d

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1950, to Jan 16, 1950, that I last saw the deceased alive on Jan. 15, 1950, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clay R. Durrett M.D. Cumberland — 1/18/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Jan 19 50

NAME OF CEMETERY OR CREMATORY: St Luke's Cem

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Jan. 19, 1950

REGISTRAR'S SIGNATURE: Wynter R. Kantz M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc

ADDRESS: Cumberland Md

496-V9

RECEIVED
JAN 24 1950
BUREAU V. S.

00004

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport | LENGTH OF STAY (in this place) 3yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS 204 Howard St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 204 Howard St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Athey
4. DATE OF DEATH: (Month) Jan (Day) 3 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 24, 1871
9. AGE last birthday 78 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Athey
14. MOTHER'S MAIDEN NAME Mathilda Ray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 705-07-7028
17. INFORMANT AND ADDRESS Edna Athey, Westernport, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval between onset and death: 1 hr

420.1 Antecedent cause(s) (b) Arteriosclerosis

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 3.45a m., from the causes and on the date stated above.

SIGNATURE Kw Leech MD (Degree or title) ADDRESS Westernport Md DATE SIGNED 1/3/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 1/5/50 | NAME OF CEMETERY OR CREMATORY St. Peters Cem | LOCATION (City, town, or county) Westernport, Md (State)

DATE REC'D BY LOCAL REG. Jan 4/50 | REGISTRAR'S SIGNATURE Registrar MD

24. FUNERAL DIRECTOR Ellsworth S. Boal. ADDRESS Westernport, Md.

322-47

RECEIVED
JAN 5 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00005

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 16 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Wilbur	Eugene	Baldwin	Jan	3	50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	Sept. 8, 1949		5	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Cumberland, Md.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wilbur E. Baldwin, Sr.	Anna Kifer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	W. E. Baldwin, Sr. Cresaptown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

340.3 81a

Immediate cause (a) Meningitis acute Etiology Unknown — Interval between onset and death: 2 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Dec 15, 1949, to Jan 3, 1950, that I last saw the deceased alive on Jan 2, 1950, and that death occurred at 2:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
R. M. Schindler MD	41 Everett Cumberland, Md	Jan 3, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 5, 1950	Glendale Cemetery	Flintstone, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 5, 1950	Wenter R. Frantz, M.D.	William H. Kight	Cumberland, Md.

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RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00006

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 8 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 711 Hill Top Drive

3. NAME OF DECEASED (Type or Print): (First) Raymond (Middle) Miles (Last) Beall

4. DATE OF DEATH: (Month) Jan. (Day) 25 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: March28-1911

9. AGE last birthday: 38 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Florist

10b. KIND OF BUSINESS OR INDUSTRY: growing flowers

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abel M. Beall

14. MOTHER'S MAIDEN NAME: Hannah Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.2

16. SOCIAL SECURITY NO. 220-10-8104

17. INFORMANT Aunt) Bertha H. Beall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

916.3 **Immediate cause** (a) 2nd, 3rd. & 4th. degree burns of body from — Interval between onset and death: 8 hrs.

181.0 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) knees to head

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) Habeeb's Green House
(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) Jan. 25 50 (Hour) 2.45 A. m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? Opened furnace door gas&flames blew out & set his clothes afire.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: Jan.25-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: January 27, 1950
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Jan. 27, 1950
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR ADDRESS: John J. Hofer, Cumberland, Md.

VS. A15A

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RECEIVED
JAN 31 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00007

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

1. PLACE OF DEATH — COUNTY: Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton; LENGTH OF STAY (in this place): ; HOSPITAL OR INSTITUTION OR STREET ADDRESS: - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton; STREET ADDRESS (If rural, give location): - - - - -

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Bean

4. DATE OF DEATH: (Month) January (Day) 23 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Mar 19, 1862

9. AGE last birthday: 87 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Hakemont ?

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Bean

14. MOTHER'S MAIDEN NAME: Mary Holmes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Thomas Bean, Detroit Michigan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x **Immediate cause** (a) Pulmonary And Generalized Edema. — Interval Between Onset And Death: One Day

830 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral Hemorrhage — Five Days

(c) Hemiplegia Left — Five Days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 20, 1950, to Jan. 23, 1950, that I last saw the deceased alive on Jan 23, 1950, and that death occurred at 9:05 P. m., from the causes and on the date stated above.

SIGNATURE: Paul R Wilson (Degree or title) M.D. ADDRESS: Piedmont W. Va. DATE SIGNED: Jan 25, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Jan 26, 50

NAME OF CEMETERY OR CREMATORY: St Gabriels Cem

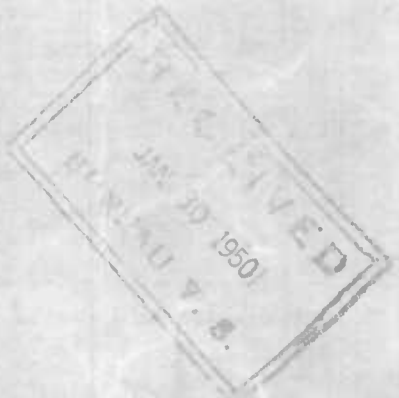
LOCATION (City, town, or county) (State): Barton, Maryland

DATE REC'D BY LOCAL REG: Jan 27 50

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: E. S. Boal ADDRESS: Westernport, Md

454-V2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Within corporate limits

00008

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital
MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Nikep
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) E. (Last) Beeman

4. DATE OF DEATH: (Month) Jan (Day) 21 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Child

8. DATE OF BIRTH: Jan 5 1950

9. AGE last birthday: [redacted] If under 1 year: Months — Days 16 | If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James R. Beeman

14. MOTHER'S MAIDEN NAME: Margaret M. Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mrs. James R. Beeman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

764.5 **Immediate cause** (a) Diarrhea

119a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10, 19 50, to 1/21, 19 50, that I last saw the deceased alive on 1/21, 19 50, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Thomas Robinson M. D. ADDRESS: 19 S. Liberty St. Cumb. Md. DATE SIGNED: 1/24/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan 23 1950

NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

LOCATION (City, town, or county) (State): Moscow, Md.

DATE REC'D BY LOCAL REG.: Jan 23, 1950

REGISTRAR'S SIGNATURE: Winter R. Hardy, M.D.

24. FUNERAL DIRECTOR: M. Eichhorn Sons

ADDRESS: Lonaconing, Md.

2-0-1-05- 0-22-2-31-R

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Within corporate limits DR. TOLSON

00009

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 3	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 102 S. LIBERTY STREET.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): CHARLES S. BERKSHIRE

4. DATE OF DEATH (Month) (Day) (Year): Jan. 30, 1950 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
MALE	WHITE	Married	about 1869 Unknown	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber	Own Business	Fairmont, West Virginia	U.S.A

13. FATHER'S NAME: FRANK F. BERKSHIRE

14. MOTHER'S MAIDEN NAME: HARRIET MAULER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerosis

450.0 Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Benign hypertrophy prostate

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-1-, 1949, to 1-30-, 1950, that I last saw the deceased alive on 1-30-, 1950, and that death occurred at 7:15 P.m., from the causes and on the date stated above.

SIGNATURE: Howard L. Tolson, M.D. (Degree or title) — ADDRESS: Cumberland, Md. — DATE SIGNED: 1-31-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Feb. 2, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 1, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: John E. Wolfort — ADDRESS: 125 S. Liberty St Cumberland

700-89

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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FEB 7 1950
BUREAU V. S.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

00010

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 519 Louisianna Avenue

3. NAME OF DECEASED (Type or Print): (First) Clara L. (Middle) (Last) Bowan
4. DATE OF DEATH: (Month) 1 (Day) 18 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 1/17/63
9. AGE last birthday: 87 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lucurgus F. Gurley
14. MOTHER'S MAIDEN NAME: Roseann Isabel Frantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: None.
17. INFORMANT AND ADDRESS: Brother - Oscar Gurley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331x **Immediate cause** (a) Cerebral Vascular Accident — 3 days

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General Arteriosclerosis — 8 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 14, 1950, to Jan. 18, 1950, that I last saw the deceased alive on Jan. 14, 1950, and that death occurred at 11:40 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Herbert F. Jones M. D. — 110 S. Centre St. — Jan. 18, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Burial — 1/20/50 — Prior Memorial Park — Near Cumberland Md

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS

Jan. 20, 1950 — Winter B. Frantz, M.D. — Lonis Stein Inc — Cumberland Md

434-89

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00011

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 3 Mo.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 307 Polk Street

3. NAME OF DECEASED (Type or Print)	(First) STEPHEN 1E	(Middle) ANN	(Last) BUCY	4. DATE OF DEATH (Month) Jan. (Day) 19, (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 20, 1949	9. AGE last birthday yrs. If under 1 year Months 3 Days 29 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. Bucy		14. MOTHER'S MAIDEN NAME Dorothy B. Carter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Robert Bucy 307 Polk St. Cumberland, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tuberculous Meningitis	4 Wks
Antecedent cause(s)	(b) Pulmonary Tuberculosis	8 Wks.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

002x

13b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1950, to 1-19, 1950, that I last saw the deceased alive on 1-19, 1950, and that death occurred at 9 15/m m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. W. Eleason	M.D.	126 Union St. Cumberland	1-20-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Jan. 21, 1950	NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	LOCATION (City, town, or county) (State) Frostburg, Md.
DATE REC'D BY LOCAL REG. Jan. 21, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz M.D.	24. FUNERAL DIRECTOR William H. Kight	ADDRESS Cumberland, Md.

2-0-9-12-9-18-1-40-R

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

Within corporate limits?

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 1hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Balt
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 21
STREET ADDRESS (If rural give location): 64 Edgewater Apt.

3. NAME OF DECEASED (Type or Print): (First) Genevieve (Middle) Revie (Last) Calhoun
4. DATE OF DEATH: (Month) Jan. (Day) 23 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	white	married	July 16-1925	24 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	home	Rodemer W.Va.	U.S.A.

13. FATHER'S NAME: Artie Messenger
14. MOTHER'S MAIDEN NAME: Stella Sypolt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		None	Husband) Roy Calhoun

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
816.5 Immediate cause	(a) Intrathoracic hemorrhage due to a crushed chest	2 hours
170 C Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bilateral pneumothorax & subcutanious emphysema of neck.	
	(c) Several lacerations of scalp.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: route 220
(CITY OR TOWN): about 9 miles South of Cumberland
(COUNTY): Allegany
(STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 23/50 8.30 A.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Sideswiped a tractor trailer truck.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H. V. Deming M.D.	Cumberland Md.	Jan. 23-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/26/1950	Terra Alta Cemetery	Terra Alta, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 25, 1950	Winter L. Hartz. M.D.	Fike & Watson,	Terra Alta, W. Va.

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00013

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 45 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: PENN. — COUNTY: BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BEDFORD
STREET ADDRESS (If rural, give location): 233 S. RICHARD ST.,

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): HOWARD CESSNA
4. DATE OF DEATH (Month) (Day) (Year): JAN. 26 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: OCT. 27, 1871
9. AGE last birthday: 78 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED Lawyer
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Rainsburg, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE CESSNA
14. MOTHER'S MAIDEN NAME: EMMA McELFISH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Memorial Hospital, City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Arteriosclerosis &

Antecedent cause(s) Myocardial degeneration

131b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Benign hypertrophy Prostate chronic nephritis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-12-, 1949, to 1-26-, 1950, that I last saw the deceased alive on 1-25-, 1950, and that death occurred at 12:08P m., from the causes and on the date stated above.

SIGNATURE: Howard R. Tolson, MD (Degree or title) — ADDRESS: Cumberland Md. — DATE SIGNED: 1-26-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan. 29, 1950 — NAME OF CEMETERY OR CREMATORY: Bedford Cemetery — LOCATION (City, town, or county) (State): Bedford, Pennsylvania

DATE REC'D BY LOCAL REG.: Jan. 26 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Fred C. Pate and Son, Bedford, Pennsylvania — ADDRESS

V26-93

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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RECEIVED
JAN 31 1950
BUREAU V. S.

Evidence for change of age shown on:

00614

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 124 FEB 7 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton; LENGTH OF STAY (in this place): 1 year; HOSPITAL OR INSTITUTION OR STREET ADDRESS: ~	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton; STREET ADDRESS (If rural give location): ~

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	George	Calvin	Coburn		Jan.	20th	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Divorced	Dec 16 1885	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Work	Farm	Elk Garden, Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lawrence Coburn	Catherine Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no no	224-28-2209	Mr. Elmer Coburn Lonaconing

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Chronic and Unspecified Congestion of Lungs	10 Days
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Muscular Degeneration	3 Years
	(c) Not Specified as Rheumatic	
	Arteriosclerosis	3 Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized Edema	2 Months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. 10, 1950, to Jan. 20, 1950, that I last saw the deceased alive on Jan. 16, 1950, and that death occurred at 6:00 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul R Wilson	M.D.	Piedmont W.Va.	Jan. 22, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 23 1950	Oak Hill Cemetery	Lonaconing, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-23-50	Janette M Pool	M. Eichhorn	Lonaconing, Md

VS. A15

OOOVV

RECEIVED
FEB 3 1950
MIRIAM V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

00015

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 116 Centre St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 116 Centre St.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) E. (Last) COMER

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8-24-1874

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Casey

14. MOTHER'S MAIDEN NAME: Annie Ball

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Anna Comer, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 **Immediate cause** (a) Arterio Sclerosis — Interval Between Onset and Death: Several years

Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 17, 1950, to Jan 18, 1950, that I last saw the deceased alive on Jan 18, 1950, and that death occurred at 8:55 P m. from the causes and on the date stated above.

SIGNATURE: W O McCane M.D. — (Degree or title) — ADDRESS: Frostburg Md — DATE SIGNED: Jan 20 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1-21-1950 — NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 1-21-50 — REGISTRAR'S SIGNATURE: Dan Laney N. Roe

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
JAN 25 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00016

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 yrs 6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Southern Hotel

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Conley

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Separated

8. DATE OF BIRTH: Jan. 19, 1865

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor

10b. KIND OF BUSINESS OR INDUSTRY?: F.O.E. (Eagles)

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Allegany County Infirmary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Congestive heart failure	2 yrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	5 yrs
	(c)	

420.1
93a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 25, 1947, to Jan. 31, 1950, that I last saw the deceased alive on Jan. 30, 1950, and that death occurred at 7:41 p. m. from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur F. Jones M.D. — ADDRESS: 110 S. Centre St. — DATE SIGNED: Feb. 2, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Feb. 2, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 2, 1950 — REGISTRAR'S SIGNATURE: Hunter R. Brantz M.D. — Rose Hill

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight Cumberland, Md.

VS-A15

210-93

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

DR. W. F. WILLIAMS

Hofer 00017

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 300 AVIRETT AVENUE

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) T. (Last) COOKERLY
4. DATE OF DEATH: (Month) JANUARY (Day) 13, (Year) 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUG. 10, 1869
9. AGE last birthday: 80 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Engineer - Retired
10b. KIND OF BUSINESS OR INDUSTRY: Railroad ~~NONE~~
11. BIRTHPLACE (State or foreign country): CALIFORNIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN COOKERLY
14. MOTHER'S MAIDEN NAME: AGNES ~~VASSAR~~ Vazare

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocardial Degeneration

422.1

Antecedent cause(s)

61

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1. T., 1950, to 1-13-, 1950, that I last saw the deceased alive on 1.13., 1950, and that death occurred at 4 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. F. Williams M.D. Cumberland 1-14-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan. 16, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Jan. 15, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, Md. — ADDRESS

322-47

260

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1950
BUREAU V. S.

Outside of City Limits

00018

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (in this place) about 20 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3 Bedford Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
STREET ADDRESS (If rural give location) R.F.D.#3 Bedford Road.

3. NAME OF DECEASED (Type or Print) (First) Emory (Middle) Judy (Last) Crites
4. DATE OF DEATH (Month) Jan. (Day) 13 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Feb.21-1896
9. AGE last birthday 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Calender operator
10b. KIND OF BUSINESS OR INDUSTRY Kelly-S.Tire Co
11. BIRTHPLACE (State or foreign country) Morefield W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Isaac H. Crites
14. MOTHER'S MAIDEN NAME Susan T.Pratt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.1
16. SOCIAL SECURITY NO. 214-07-0341
17. INFORMANT brother)Leo B.Crites

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary sclerosis	?
	(c)	Chronic myocarditis	?

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V.Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Jan.13-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 1/16/1950
NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park
LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Jan. 16, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

496-2V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00019

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Oldtown — LENGTH OF STAY (in this place): 5 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Oldtown Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route I	STREET ADDRESS (If rural, give location): Route I

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Amos	Crites	Jan	20	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	1/9/89	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Self Employed	Grant Co W. Va	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Arch Crites	Sena V. Weiss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		Earl Crites, Oldtown Rt I.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tuberculosis Pulmonary	5-20 yrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-11-, 1950, to ....., 19....., that I last saw the deceased alive on 1-11-50, 19....., and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE: J. T. Armstrong (Degree or title) M.D. ADDRESS: Paw Paw W. Va DATE SIGNED: 1-20-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 22 1950	Baptist Church Cemetery	Near Petersburg W. Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 20-1950	Sue C. Gimeran	John J. Hafer	Cumberland, Md.

308-V9

RECEIVED
JAN 23 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 86 Bowery St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 86 Bowery St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARY	JANE	CRUMP	Jan.	25	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
female	white	widowed	11-18-1863	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Frostburg, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Taylor	Mary Jeffries

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	none	Taylor Crump, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
2418 Immediate cause	(a) Acute Congestive Heart Failure	6 hrs
112 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bronchial asthma, over-etiol?	20 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb., 1949, to 25 Jan., 1950 that I last saw the deceased alive on 25 Jan., 1950, and that death occurred at 9 30 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John B. Davis	M D	Frostburg, Md	1/27/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-28-50	Allegany Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
1-28-50	Mrs. Nancy N. Roe	J. R. Durst, Frostburg, Md.

RECEIVED
FEB 3 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00621

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegheny — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jennings
STREET ADDRESS (If rural, give location) Rural ✓

3. NAME OF DECEASED (Type or Print): (First) steven (Middle) Columbus (Last) Custer

4. DATE OF DEATH: (Month) Jan (Day) 2 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify):

8. DATE OF BIRTH: Nov. 17, 1886

9. AGE last birthday: 63 yrs. If under 1 year: Months 1 Days 15 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sawmill Labor

10b. KIND OF BUSINESS OR INDUSTRY: Sawmill

11. BIRTHPLACE (State or foreign country): Rural Jennings Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Michael Custer

14. MOTHER'S MAIDEN NAME: Maria Feren

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-03-7196

17. INFORMANT: Myrtle Custer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: 3 days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension —

(c) Arterio - sclerosis —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. — as above

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-21, 1949, to 1-2, 1950, that I last saw the deceased alive on 1-2, 1950, and that death occurred at 2:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. C. Diehl M.D. Frostburg, Md. 1/2/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan 5, 1950 — NAME OF CEMETERY OR CREMATORY: Grantsville Cemetery — LOCATION (City, town, or county) (State): Grantsville, Maryland

DATE REC'D BY LOCAL REG. 1-3-50 — REGISTRAR'S SIGNATURE: Mrs. Laney N. Roe

24. FUNERAL DIRECTOR: Wm Winterberg — ADDRESS: Grantsville, Md.

988-09

RECEIVED
JAN 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00022

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Klondike — LENGTH OF STAY (in this place) — HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Klondike — STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mabel	Christine	Cutter	Jan	18	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Married	Nov 14, 1905	44 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House work	Own Home	Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Cutter	Jenny McMurdo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
		William Cutter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

199.8 **Immediate cause** (a) Metastatic carcinoma — 1 year

55e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with undetermined primary site

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from December, 1949, to January, 1950, that I last saw the deceased alive on Dec 23, 1950, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Lyle DeFerrari	M.D.	Frostburg Md.	1-20-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 21, 1950	Cutter Cemetery	Allegany County, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-23-50	Jennett M Coal	M. Eichhorn	Lonaconing, Md.

VS. A15

RECEIVED
FEB 3 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00023

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural give location): York Hotel

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	William	Dahl	Jan.	3	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	Divorced	Nov. 29-1892	57 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
baker	Restaurant	Mill Run, Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Dahl	Rachael Beals

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes W.W.1	220-10-2026	Daniel Dahl, Windsor Hotel, City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial infarct due to coronary occlusion-	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) from coronary sclerosis.	?
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	Jan. 4-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 6-1950	St. Peters & Paul Catholic Cemetery	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 6, 1950	Walter R. Wantz, M.D.	John J. Hafer, Cumberland Md.

300-71

RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00024

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. MARGIN RESERVED FOR BINDING
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (In this place) 3HRS. 25MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY GRANT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG
STREET ADDRESS (If rural, give location) 5 MYRTLE AVENUE ✓

3. NAME OF DECEASED (Type or Print): (First) EDGAR (Middle) VANCE (Last) DAUGHERTY, Jr
4. DATE OF DEATH: (Month) JANUARY (Day) 4 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	1-29-1915	34 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CLERK	FEED STORE	WEST VIRGINIA	U.S.A.

13. FATHER'S NAME: EDGAR V. DAUGHERTY
14. MOTHER'S MAIDEN NAME: MALENDIA WOLF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.	232-262-245	MEMORIAL HOSPITAL-CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

971.6 **Immediate cause** (a) ARSENICAL POISONING — INTERVAL BETWEEN ONSET AND DEATH: ABOUT 5½ HOURS.

163g **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	WAREHOUSE IN PETERSBURG	PETERSBURG.	GRANT	W. VA.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐	Not while at work ☒	HOW DID INJURY OCCUR?
1-3-50 10:30P m.			DRANK RAT POISON, SUICIDAL INTENT

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H. V. DEMING, MD. H. V. Deming M.D.	CUMBERLAND, MARYLAND	1-4-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 6, 1950	Maple Hill Cemetery	Petersburg, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 4, 1950	Walter R. Hantz, M.D.	P. E. Swisher and Son - Petersburg,	West Virginia

266-78

VS. A15A

RECEIVED
JAN 10 1950
BUREAU V. S.

Outside of City Limits

00025

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland rural
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#4

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
STREET ADDRESS (If rural give location) R.F.D.#4

3. NAME OF DECEASED (Type or Print) (First) Maude (Middle) Dunlap (Last) Davis
4. DATE OF DEATH (Month) Jan. (Day) 29 (Year) 1950

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Jan.18-1883
9. AGE last birthday 67 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Curvensville Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Dunlap
14. MOTHER'S MAIDEN NAME Mildred Schimmel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT John F.Davis, Rt.#4, City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: at once

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis with hypertention — at least 6 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Jan.29-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 2-1-1950
NAME OF CEMETERY OR CREMATORY Davis Memorial
LOCATION (City, town, or county) (State) Near Cumberland, Md.

DATE REC'D BY LOCAL REG. Jan. 31, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00026

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 15 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 128 Frederick St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 128 Frederick St

3. NAME OF DECEASED (Type or Print): (First) Liza (Middle) Jane (Last) Deitz

4. DATE OF DEATH: (Month) Jan (Day) 23 (Year) 1950

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed | 8. DATE OF BIRTH: May 9 1859 | 9. AGE last birthday: 90 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework | 10b. KIND OF BUSINESS OR INDUSTRY: At Home | 11. BIRTHPLACE (State or foreign country): Bedford Valley Pa | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Cessna | 14. MOTHER'S MAIDEN NAME: Sidney Ann Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT AND ADDRESS: Mrs Walter Frantz, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval between Onset and Death: 1 year

422.2 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1950, to Jan 23, 1950, that I last saw the deceased alive on Jan 22, 1950, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
R. W. Trevaskis, Dr | Cumberland, Md | 1/23/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Jan 25 '50 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem | LOCATION (City, town, or county) Cumberland | (State) Md

DATE REC'D BY LOCAL REG. Jan. 25, 1950 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR Louis Stein Inc | ADDRESS Cumberland

RECEIVED
JAN 31 1950
BUREAU V. S.

00027

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
STREET ADDRESS (If rural, give location) Rt 40 West

3. NAME OF DECEASED (Type or Print) (First) Mildred (Middle) Laney (Last) DeVries
4. DATE OF DEATH (Month) Jan (Day) 18 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov 27 1889
9. AGE last birthday 60 yrs. If under 1 year Months, Days; If under 24 hrs. Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Jack Laney
14. MOTHER'S MAIDEN NAME Anna Mary Elizabeth Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Wm. DeVries La Vale Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
150X	Immediate cause	(a) Esophageal Hemorrhage	8 hours
46a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Adenocarcinoma Esophagus	3 months
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION December 1949
19b. MAJOR FINDINGS OF OPERATION Biopsy clavicular node — Adenocarcinoma
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 1949, to Jan. 18, 1950, that I last saw the deceased alive on Jan. 18, 1950, and that death occurred at 5 15 P m., from the causes and on the date stated above.

SIGNATURE Hilda Jane Walters, M.D. (Degree or title) ADDRESS 48 Broadway Frostburg Md DATE SIGNED 1/18/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1/21/50
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Jan. 21, 1950
REGISTRAR'S SIGNATURE Mrs Nancy N. Roe
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1950
BUREAU V. S.

Within corporate limit.

Weisman

00028

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Willowbrook Road Rt 2

3. NAME OF DECEASED (Type or Print) (First) Paul (Middle) John (Last) Dircks Sr.

4. DATE OF DEATH (Month) Jan (Day) 12 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married.
8. DATE OF BIRTH ~~Unknown~~ about 1865
9. AGE last birthday 84 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Self Employed
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Paul Dircks
14. MOTHER'S MAIDEN NAME Mary Geganus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. Paul Dircks, Sr, City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hepatorenal failure	3 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac failure due to Arteriosclerotic	11 days
	(c) Heart Disease c̄ auricular fibrillation	

420.0

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION No
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No (CITY OR TOWN) No (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from July, 1949, to Jan 12, 1950, that I last saw the deceased alive on Jan 12, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

SIGNATURE Saville G Weisman (Degree or title) MD ADDRESS 122 Bedford St Cumberland, Md DATE SIGNED 1/14/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 16, 1950
NAME OF CEMETERY OR CREMATORY St Patricks Catholic Cem.
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Jan. 15, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR John J. Hafer - Cumberland Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
JAN 24 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00029

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown, Md.
STREET ADDRESS (If rural, give location): -----

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Delbert	Harold	Evans	1	7	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours. Min.
Male	White	Single	1/7/83	26 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Armstrong Co. New Haven, Conn.	East Rainelle, W. Va.	U.S.

13. FATHER'S NAME: Jos. Evans
14. MOTHER'S MAIDEN NAME: Delta R. Richman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		199-12-9142	Brother - Dexter Evans

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

345x **Immediate cause** (a) Multiple Sclerosis — Interval between onset and death: 2½ yrs

87d **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 14, 1949, to Jan. 7, 1950, that I last saw the deceased alive on Jan. 7, 1950, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Jan. 7, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 10, 1950	Methodist Cemetery	Mt. Savage, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 9, 1950	Winifred K. Hardy, M.A.	John J. Hafer, Cumberland,	"

98-24

RECEIVED
JAN 17 1950
BUREAU V. S.

Within corporate limits

00030

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (In this place) Lodge
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyndman
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Jacob (Middle) S. (Last) Evans

4. DATE OF DEATH: (Month) Jan. (Day) 20 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Nov. 19, 1877

9. AGE last birthday: 72 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Telegrapher - Retired

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Hyndman, Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Evans

14. MOTHER'S MAIDEN NAME: Sarah Moses

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Cora Evans

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.0	Immediate cause	(a) Coronary Thrombosis	5 minutes
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arterio Sclerotic Heart Disease	15 yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hemorrhoidectomy

19a. DATE OF OPERATION: Jan 17-1950

19b. MAJOR FINDINGS OF OPERATION: Internal + External Hemorrhoids

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1940, to Jan 20, 1950, that I last saw the deceased alive on Jan 20, 1950, and that death occurred at 9 50 P m., from the causes and on the date stated above.

SIGNATURE: Thos A Topper (Degree or title) MD — ADDRESS: Hyndman Pa — DATE SIGNED: Jan 22, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 25 1950 — NAME OF CEMETERY OR CREMATORY: Hyndman — LOCATION (City, town, or county) (State): Hyndman Pa

DATE REC'D BY LOCAL REG.: Jan. 23, 1950 — REGISTRAR'S SIGNATURE: Walter R. Hartz, M.D. — 24. FUNERAL DIRECTOR: Harvey N. Leigler — ADDRESS: Hyndman, Pa

V86-49

VS. A15

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

00031

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa. — COUNTY: Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hyndman
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) H. (Middle) Somers (Last) Fischer

4. DATE OF DEATH: (Month) Jan. (Day) 3 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: Apr. ? 1882

9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jewler

10b. KIND OF BUSINESS OR INDUSTRY: Merchant

11. BIRTHPLACE (State or foreign country): Mann's Choice Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Fisher

14. MOTHER'S MAIDEN NAME: Amanda Stuck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkoown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 2nd. & 3rd. degree burns, chest, neck, face & head & arms. — 8 days

916.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under ying cause last

180

(b) trying to remove wife from burning home.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: home

(CITY OR TOWN): Hyndman (COUNTY): Bedford (STATE): Pa.

TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 25, 1949 P m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Trying to remove wife from burning home.

22. *I certify thot I took charge of the remoins described obove, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, occident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: H. V. Deming M. D. Cumberland Md. — DATE SIGNED: Jan. 3-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Jan. 5 1950

NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

LOCATION (City, town, or county) (State): Hyndman, Pennsylvania

DATE REC'D BY LOCAL REG.: Jan. 5, 1950

REGISTRAR'S SIGNATURE: Virgil K. Frantz, M.D.

24. FUNERAL DIRECTOR: Harvey D. Zeigler, Hyndman, Penna. — ADDRESS

156-76

VS. A15A

RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits

Dr Mirkin
~~DR. A. JONES~~

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00032

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 6 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location): 20 NORTH CHASE ST.,

3. NAME OF DECEASED (Type or Print)	(First) HARRY	(Middle) Wilson	(Last) FLOTO	4. DATE OF DEATH	(Month) JAN. (Day) 25 (Year) 1950
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED	8. DATE OF BIRTH: DEC. 29 1884	9. AGE last birthday: 65 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman	10b. KIND OF BUSINESS OR INDUSTRY: Stationary Supplies	11. BIRTHPLACE (State or foreign country): Berlin, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: CHARLES FLOTO	14. MOTHER'S MAIDEN NAME: RUTH ~~KERL~~ Karel				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
144X Immediate cause	(a) Lobar Pneumonia & Empyema (Rt)	2-3 wks.
Antecedent cause(s)		
45c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of mouth c̄ metastases	12-15 mo
	(c) Peptic ulcer; emaciation	3-6 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1-23-50	19b. MAJOR FINDINGS OF OPERATION: Contracted stomach; ulcer ant. wall of antrum	20. AUTOPSY? Yes ☑ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): No	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-22, 1950, to 1-25, 1950, that I last saw the deceased alive on 1-25, 1950, and that death occurred at 11 05 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A J Mirkin	MD	115 So. Centre St	1/27/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: January 28, 1950	NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery	LOCATION (City, town, or county) (State): Berlin, Pa.
DATE REC'D BY LOCAL REG.: Jan. 28, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, Md.	ADDRESS

278-60

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

00033

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS 856 Gephart Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 856 Gephart Drive

3. NAME OF DECEASED (Type or Print): [redacted] (First) .Georgia (Middle) Flurshutz (Last)

4. DATE OF DEATH: (Month) Jan (Day) 18 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 17 1908

9. AGE last birthday: 41 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland U.S.A.

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME: John C. Hoffman

14. MOTHER'S MAIDEN NAME: Ella Crothers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yr., give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-22-6869

17. INFORMANT: Arthur Flurshutz, City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

581.0

Antecedent cause(s)

124 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 10, 1949, to Jan 18, 1950, that I last saw the deceased alive on Jan 18, 1950, and that death occurred at 12:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. W. Trevaskis Jr M.D. Cumberland, Md 1/19/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Jan. 21, 1950

NAME OF CEMETERY OR CREMATORY: St. Lukes Cemetery

LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Jan. 20, 1950

REGISTRAR'S SIGNATURE: Winter K. Hanby, M.D.

24. FUNERAL DIRECTOR: John C. Wolford, Cumberland, "

ADDRESS

RECEIVED
JAN 24 1950
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

00034

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Oakland, Rural
STREET ADDRESS (If rural give location): Cabin Lodge, Deep Creek Lake. ✓

3. NAME OF DECEASED (Type or Print): (First) Edwin (Middle) E. (Last) Fry

4. DATE OF DEATH: (Month) Jan. (Day) 9 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: March 1-1904

9. AGE last birthday: 45 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner of Cabin Lodge

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Greensburg, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank L. Fry

14. MOTHER'S MAIDEN NAME: Carrie Alcorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Louise Lauer Fry

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia due to — Interval between onset and death: 11 days

Antecedent cause(s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last — 874.0 / 179X

(b) hemorrhagic nephritis from accidently

(c) drinking Chloroform Lin't. for paraldehyde.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: home
(CITY OR TOWN): Oakland (COUNTY): Garrett (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 27/49 m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? for Paraldehyde. Took Chloroform Lin't. by mistake

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Jan. 10-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Jan. 13 1950 — NAME OF CEMETERY OR CREMATORY: Oakland Cemetery — LOCATION (City, town, or county) (State): Oakland, Maryland

DATE REC'D BY LOCAL REG.: Jan. 11, 1950 — REGISTRAR'S SIGNATURE: Walter K. Mintz. M.D.

24. FUNERAL DIRECTOR — ADDRESS: Emroy Golden, Oakland, Maryland

156-71

RECEIVED
DEC 17 1950
KI KPAU V. S.

Within corporate limits

00035

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 37 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 315 Holland St.	STREET ADDRESS (If rural, give location): 315 Holland St.

3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) C.	(Last) GRAHAM	4. DATE OF DEATH (Month) Jan. (Day) 23, (Year) 1950
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: March 7, 1875	9. AGE last birthday: 74 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass Worker	10b. KIND OF BUSINESS OR INDUSTRY: Glass	11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Benjamin Graham		14. MOTHER'S MAIDEN NAME: ?? Taylor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Mrs. T.E.Hobrock, Cumberland, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiovascular disease

422.1

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) High blood pressure

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/15, 1950, to 1/23, 1950, that I last saw the deceased alive on 1/22, 1950, and that death occurred at A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John N. Rozum M.D. — ADDRESS: Cumberland — DATE SIGNED: 1/23/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 1/25/1950	NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: Jan. 25, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS.A15

496-25

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00036

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland, Md, Rural
STREET ADDRESS (If rural, give location) Eastman Road R.F.#3

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) S. (Last) Griffith
4. DATE OF DEATH: (Month) 1 (Day) 25 (Year) 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: Sept. 8, 1875
9. AGE last birthday: 74 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired R.R. Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Grafton, W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Griffith
14. MOTHER'S MAIDEN NAME: Elizabeth Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Sister-in-law Mrs. Griffith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
3311 Immediate cause	(a) Cerebral Vascular Accident	10 Mins
Antecedent cause(s)		
8320 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arteriosclerosis	5 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 17, 1949, to Jan. 25, 1950, that I last saw the deceased alive on Jan. 25, 1950, and that death occurred at 8:55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Arthur F. Jones M.D. | 110 S. Centre St. | Jan. 26, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: January 28, 1950 | NAME OF CEMETERY OR CREMATORY: Maplewood Cemetery | LOCATION (City, town, or county) (State): Elkins, W. Va.

DATE REC'D BY LOCAL REG.: Jan. 27, 1950 | REGISTRAR'S SIGNATURE: Walter R. Wantz M.D. | 24. FUNERAL DIRECTOR: John J. Hofer | ADDRESS: Cumberland, Md.

322-47

VS. A15

RECEIVED
JAN 31 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00037

CERTIFICATE OF DEATH

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

wh 1/25/50

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage — LENGTH OF STAY (in this place): 1 mo.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Morantown, Frostburg, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Old Row	STREET ADDRESS (If rural give location): R. D. #2 Box 45

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Thomas	Harris	1	16	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	9-18-1891	59 58 yrs.	3	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal Mines	Eckhart, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Harris	Kathaleen Cross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	220-10-2277	Mrs. John T. Harris RD#2 Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
523.0 Immediate cause	(a) Acute congestive Heart failure	1 hour
Antecedent cause(s)		
114a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Miners Asthma	10 yrs.
	(c) Silicosis	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from May, 1948, to 15 Jan., 1950, that I last saw the deceased alive on 15 Jan., 1950, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John B. Davis	M D	Frostburg, Md	1/[illegible]/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1-18-50	Porter's Cemetery	Eckhart	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 17, 1950	Veronica McDermott	Jacob Hafer	Frostburg, Md.

454 V2

00038

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH- COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location): Church Hill

3. NAME OF DECEASED (Type or Print): (First) MINNIE (Middle) ESTELLA (Last) HAUS
4. DATE OF DEATH: (Month) Jan. (Day) 24, (Year) 1950
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 11-16-1899
9. AGE last birthday: 50 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Mikesell
14. MOTHER'S MAIDEN NAME: Alice Lynch
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT AND ADDRESS: William Haus, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

441x

Antecedent cause(s)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malignant Hypertension

(c) Hypertensive heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1948, to Jan. 24, 1950, that I last saw the deceased alive on Jan. 24, 1950, and that death occurred at 1:45 A.m., from the causes and on the date stated above.

SIGNATURE: James P. Hallinan (Degree or title) M.D. — ADDRESS: 200 Decatur St, Cumberland Md — DATE SIGNED: 1/25/50

23. BURIAL, CREMATION REMOVAL (Specify): burial
DATE: Jan 26-50
NAME OF CEMETERY OR CREMATORY: Methodist Cemetery
LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: Jan 26 - 50
REGISTRAR'S SIGNATURE: Veronica McDermott
24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 30 1950
BUREAU V. S.

Within corporate limits

00039

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

(M)

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

(I)

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 745 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Nora (Middle) O. (Last) Hess

4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 8/19/70

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Flintstone, Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Francis Twigg

14. MOTHER'S MAIDEN NAME: Alice Kifer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Son - Francis Hess

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	5 wks
Antecedent cause(s) 420.1		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 932	(b) Chronic Myocarditis	5 yrs
	(c) Coronary Sclerosis	10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 16, 1949, to Jan. 21, 1950, that I last saw the deceased alive on Jan. 20, 1950, and that death occurred at 4:15 a m., from the causes and on the date stated above.

SIGNATURE Arthur F. Powell M.D. (Degree or title) ADDRESS 110 S. Centre St. DATE SIGNED Jan. 22, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE 1/23/50 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Jan. 23, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, MD

24. FUNERAL DIRECTOR: John J. Hofer — ADDRESS: Cumberland, Md.

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporation: Waitworth

00040

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~OAKLAND~~ CUMBERLAND — LENGTH OF STAY (in this place): 1 day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: OAKLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): Greene St.

3. NAME OF DECEASED (Type or Print): (First) BABY BOY (Middle) HINEBAUGH (Last)

4. DATE OF DEATH: (Month) 1 (Day) 8 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 1-7-50

9. AGE last birthday: yrs. — If under 1 year: Months, 1 Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: HINEBAUGH, Daniel M.

14. MOTHER'S MAIDEN NAME: RINGER, Juanita J.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Daniel M. Hinebaugh Oakland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial Hemorrhage

760.0

Antecedent cause(s)

160a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Birth Trauma

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE: Fuller B. Whitworth (Degree or title) M.D. — ADDRESS: 112 Bedford St. Cumb. Md. — DATE SIGNED: 9 Jan 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan 10 '50 — NAME OF CEMETERY OR CREMATORY: Terra Alta Cem. — LOCATION (City, town, or county): Terra Alta (State): W Va

DATE REC'D BY LOCAL REG.: Jan. 9, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumberland Md.

2-0-1-07-0-24-1-40-4

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 17 1950
BUREAU V. S.

Within corporate limits

00041

Rec'd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural, give location) 158 Polk St

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Eddy (Last) Howsare
4. DATE OF DEATH (Month) Jan (Day) 26 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Aug. 24, 1876
9. AGE last birthday 73 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Ruby
14. MOTHER'S MAIDEN NAME Catherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Coyle Howsare - 158 Polk St - City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 Hrs

Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — Unknown

(c) Decubitus ulcer

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arthritis Hypertrophic — Unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/24, 1950, to 1/26, 1950, that I last saw the deceased alive on 1/26, 1950, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Denis T McS Md. ADDRESS 404 N Carter St Cumbd Md DATE SIGNED 1/27

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1/28/50
NAME OF CEMETERY OR CREMATORY Beans Cove Methodist Cem.
LOCATION (City, town, or county) Beans Cove (State) Pa.

DATE REC'D BY LOCAL REG. Jan. 28, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J Hofer ADDRESS Cumberland Md

Rec'd

RECEIVED
JAN 31 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

66642

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural near Mt Savage; MARYLAND; LENGTH OF STAY (In this place): 4 mo.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Slabtown

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Mt. Savage; STREET ADDRESS (If rural give location): Slabtown

3. NAME OF DECEASED (Type or Print): (First) Linda (Middle) (Last) Hubbard

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Dec.26-1948

9. AGE last birthday: 1 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Vivian Mc Kenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Ruth Tabler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

916.0 **Immediate cause** (a) 2nd.3rd.& 4th.degree burns of body — Interval between onset and death: about 10 min.

180 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) explosion & house burned.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home near (CITY OR TOWN) Mt.Savage(Slabtown) (COUNTY) Allegany (STATE) Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY: Jan.18/50 12.30 A.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Explosion & house burned.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, (undetermined ☒ explosion, origin)*

SIGNATURE: H.V.Deming M.D. H.V.Deming M.D. (Degree or title) ADDRESS: Cumberland Md. DATE SIGNED: Jan.18-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: 1-20-50 NAME OF CEMETERY OR CREMATORY: Porter Cemetery LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG.: 1-20-50 REGISTRAR'S SIGNATURE: Dan. Harvey N. Rae

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

VS. A15A

RECEIVED
JAN 25 1950
BUREAU V. S.

Within corporate limits Dr. W. F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

00C43

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 3
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA — COUNTY MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KEYSER
STREET ADDRESS (If rural, give location) 42 ORCHARD STREET ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
LENA	Mc Neill	HUTSON	JAN. 31 19 5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
FEMALE	WHITE	WIDOW	Aug. 3 1873	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Moore's Fork WEST VIRGINIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SEYMOUR MC NEILL	~~SEYMOUR~~ Lena Renick Mc Neill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Dr. L. M. Hudgens MEMORIAL HOSPITAL Petersburg W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Nephritis (uremia)	2 days
450.0 Antecedent cause(s)		
13/0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arteriosclerosis	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-29-, 1950, to 1-31-, 1950, that I last saw the deceased alive on 1-31-, 1950, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams	M.D.	Cumberland	1-31-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 2 1950	~~Petersburg~~ Maple Hill Cem.	Petersburg	W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 31, 1950	Walter R. Hartz, M.D.	B-W Markwood	Keyser W.Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1950
BUREAU V. S.

00644

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 3 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) Edward (Last) Jeffries
4. DATE OF DEATH (Month) Jan (Day) 3 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Aug 29, 1896
9. AGE last birthday 53 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender
10b. KIND OF BUSINESS OR INDUSTRY Own Bar
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Henry Jeffries
14. MOTHER'S MAIDEN NAME Annie Stevens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) World War
16. SOCIAL SECURITY NO. 1
17. INFORMANT Mrs Irvin Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
416x	Immediate cause	(a) Rheumatic heart disease	5 yrs.
131a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	5 yrs.
		(c) Nephrosclerosis	2 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1947, to Jan 3, 1950, that I last saw the deceased alive on Jan 3, 1950, and that death occurred at 10 30 P m., from the causes and on the date stated above.

SIGNATURE W. E. Gattens (Degree or title) M.D. ADDRESS Frostburg Md. DATE SIGNED 1/6/50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Jan 6, 1950
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 1-6-50
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing, Md.

710-71

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M I T VS. A15

RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits

00045

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 8 Harrison Street

3. NAME OF DECEASED (Type or Print) (First) Hugh (Middle) John (Last) Kelley
4. DATE OF DEATH (Month) 1 (Day) 24 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Aug 23 1871
9. AGE last birthday 78 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Taxi Driver
10b. KIND OF BUSINESS OR INDUSTRY Wk Business
11. BIRTHPLACE (State or foreign country) Piedmont, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Kelley
14. MOTHER'S MAIDEN NAME Mary Melody

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. none
17. INFORMANT AND ADDRESS Mrs Cecelia Kelley, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Myocardial failure	2 days
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Chronic Myocarditis	3 yrs.
	(c)	Coronary sclerosis	3 yrs

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 18, 1949, to Jan. 24, 1950, that I last saw the deceased alive on Jan. 22, 1950, and that death occurred at 6:20 a m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones M.D. (Degree or title) ADDRESS 110 S. Centre St. DATE SIGNED Jan. 24, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 26 50
NAME OF CEMETERY OR CREMATORY Sts Pet & Paul Cem.
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Jan. 25, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumb'd Md.

450-56

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 27 1950
BUREAU V. S.

00046

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): 10 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Vale Summit
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Edna (Middle) Elizabeth (Last) Kenney
4. DATE OF DEATH: (Month) 1 (Day) 11 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 5-2-1910
9. AGE last birthday: 39 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Vale Summit, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Loar
14. MOTHER'S MAIDEN NAME: Lulu Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs Lulu Henry, Vale Summit Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

414X Immediate cause (a) Rheumatic Endocarditis — Several years

Antecedent cause(s)

91c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. 5 months Pregnancy

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 5, 1949, to Jan 11, 1950, that I last saw the deceased alive on Jan 11, 1950, and that death occurred at 5:15 P m., from the causes and on the date stated above.

SIGNATURE: W O M Lane MD (Degree or title) — ADDRESS: Frostburg Md — DATE SIGNED: Jan 13 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 1-14-1950 — NAME OF CEMETERY OR CREMATORY: St. Michaels — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 1-14-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe — 24. FUNERAL DIRECTOR: Jacob Hafer, Frostburg, Md. — ADDRESS:

649

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00647 McFarr

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg; LENGTH OF STAY (in this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cumberland, Md.; STREET ADDRESS (If rural, give location) Red Hill

3. NAME OF DECEASED (Type or Print): (First) MARY; (Middle) LOUISE; (Last) LABER

4. DATE OF DEATH: (Month) Jan.; (Day) 28; (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 9-13-1874

9. AGE last birthday: 75 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Clise

14. MOTHER'S MAIDEN NAME: Venie Winters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: James Laber, Eckhart, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 Days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rt Hemiplegia — ? ? ?

(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 24, 1950, to Jan 28, 1950, that I last saw the deceased alive on Jan 27, 1950, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W O McC Lane M.D. Frostburg Md Jan 30 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 1-31-50

NAME OF CEMETERY OR CREMATORY: Allegany Cemetery

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 1-31-50

REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

RECEIVED
FEB 3 1950
BUREAU F. S.

Within corporate limits

DR. COOPER

Mail to Health Dept Cumberland, Md when signed 00048

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: WEST VIRGINIA; COUNTY: MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY in this place: 6½ HOURS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: KEYSER,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): ROUTE #3 ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Mooth)	(Day)	(Year)
BABY	BOY	LANCASTER	JAN.	28,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	WHITE		1/27/50			6 / 30

10a. USUAL OCCUPATION (Give kiod of work dooe during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		CUMBERLAND, MD.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
MELVIN LANCASTER	VALARIE E. TURNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowo)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		None	MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Anoxia

772.0 **Antecedent cause(s)** —

Diseases or conditions, if any, giving rise to the above cause statiog the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but oot related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Mooth) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L.S. Cooper (Per W.R. Hodges, M.D.)		Cumberland, Md.	1/28/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 31, 1950	Wardler Cemetery	Wardler, Mineral Co, W Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 30, 1950	Winter R. Mantz, M.D.	E. S. Boal	Western Port

2-0-1-27-0-22-2-36-2.

XVX99 -md

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

Dr. Murray

00049

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 1½ days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) JOSEPH	(Last) LANCASTER	4. DATE OF DEATH	(Month) JAN. (Day) 4 (Year) 1950
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 3-8-1932	9. AGE last birthday: 17 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Wm. Lancaster		14. MOTHER'S MAIDEN NAME: Lilliam McKenzie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT AND ADDRESS: Wm. Lancaster, Mt. Savage, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Double Base Tobac Pneumonia	7 days
Antecedent cause(s)	(b) Eruptive cold	10 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Enlarged heart	

480X

108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Deformed chest & body

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1950, to Jan 4, 1950, that I last saw the deceased alive on Jan 3, 1950, and that death occurred at 815a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
F. Alan G. Murray	Md	Cumberland Md	Jan 6 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 1-7-50	NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery	LOCATION (City, town, or county) (State): Mt. Savage, Md.
DATE REC'D BY LOCAL REG.: Jan. 6, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

XVX99

RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits

Dr. Simons

For change of birth date and age shown on:

FILM No. G 124 JAN 20 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00650

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Alleg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 506 Pine Avenue

3. NAME OF DECEASED (Type or Print): (First) Wayne B. (Middle) (Last) Lipscomb

4. DATE OF DEATH: (Month) Jan. (Day) 12 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: Nov. 1, 1895

9. AGE last birthday: 53 57 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B & O carman helper

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Allen Lipscomb

14. MOTHER'S MAIDEN NAME: Hazel M. Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 272-10-3502

17. INFORMANT AND ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Cardiac failure	2 weeks
442X Antecedent cause(s)		
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive cardiovascular renal disease	1 year
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November, 1949, to Jan. 12, 1950, that I last saw the deceased alive on Jan. 11, 1950, and that death occurred at 7:45 AM, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George W. Simons	M.D.	151 Vaught Cumberland, Md.	1/12/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 14, 1950	Parsons Cemetery	Parsons	W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 13, 1950	Walter R. Mantz, M.D.	John J. Hafer	Cumberland, Md.

H16-47

RECEIVED
JAN 17 1950
BUREAU U. S.

Within corporate limits DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00051

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 45 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: WEST VIRGINIA — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FORT ASHBY
STREET ADDRESS (If rural, give location): √

3. NAME OF DECEASED (Type or Print): (First) CLAYTON (Middle) R. (Last) LONG

4. DATE OF DEATH: (Month) JANUARY (Day) 31, (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: APRIL 18, 1872

9. AGE last birthday: 77 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: JAMES LONG

14. MOTHER'S MAIDEN NAME: [redacted] Katherine Lippold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemiplegia - left — Interval Between Onset and Death: 2 mos.

334 X Antecedent cause(s)

83d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Infirmities of age

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 16, 1949 to 1-31, 1950, that I last saw the deceased alive on 1-31, 1950, and that death occurred at 11:30 P m., from the causes and on the date stated above.

SIGNATURE: W. F. Williams (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: 2/1/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 2-3-1950

NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery

LOCATION (City, town, or county) (State): Fort Ashby, W. Va.

DATE REC'D BY LOCAL REG.: Feb 3 1950

REGISTRAR'S SIGNATURE: Winter K. Hantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

000VV

RECEIVED
FEB 7 1950
BUREAU V. S.

00652

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Henry (Last) Lowery

4. DATE OF DEATH (Month) January (Day) 9 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 3, 1869
9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Lowery
14. MOTHER'S MAIDEN NAME Lucinda Sturtz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Lucinda Lowery

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Arteriosclerotic Cardio-Vascular — INTERVAL BETWEEN ONSET AND DEATH 10 yrs.

442X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Renal Disease

131a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1950, to Jan 9, 1950, that I last saw the deceased alive on Jan 9, 1950, and that death occurred at 11.40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A Topper MD ADDRESS Hyndman Pa DATE SIGNED 1-10-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 1/13/50
NAME OF CEMETERY OR CREMATORY Porters Cemetery
LOCATION (City, town, or county) Hyndman, Pa (State)

DATE REC'D BY LOCAL REG. Jan 11 1949
REGISTRAR'S SIGNATURE J. Lloyd Wolfe
24. FUNERAL DIRECTOR Harvey H. Ziegler ADDRESS Hyndman Pa.

988-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 13 1950
BUREAU V. S.

00053

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY: Allegheny MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY: Allegheny
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCool. LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCool
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 36 Maryland Ave.	STREET ADDRESS (If rural, give location): 36 Maryland Ave.,

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Joseph William Malcolm				4. DATE OF DEATH (Month) (Day) (Year): Jan. 5, 1950 19	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Mar. 16, 1877	9. AGE last birthday: 72 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carman	10b. KIND OF BUSINESS OR INDUSTRY: B.& O.R.R.	11. BIRTHPLACE (State or foreign country): Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: John Malcolm,		14. MOTHER'S MAIDEN NAME: Mary Murphy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 705-09-7280	17. INFORMANT AND ADDRESS: Mrs. J. W. Malcolm.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443X Immediate cause	(a) Pulmonary oedema	1 day
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac enlargement (myocarditis chronic	12 years
	(c) arteriosclerosis, and hypertension	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: nil	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify): nil	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-5, 1950, to 1-5, 1950, that I last saw the deceased alive on 1-5, 1950, and that death occurred at 11:30 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. Griffin	M D	Keyser W Va	1-5-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE: 1/7/50	NAME OF CEMETERY OR CREMATORY: Queens Point	LOCATION (City, town, or county) (State): Keyser, Mineral, W. Va.
DATE REC'D BY LOCAL REG.: 1/6/50	REGISTRAR'S SIGNATURE: [illegible] M.D.	24. FUNERAL DIRECTOR: B. W. Markwood, Keyser W Va.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

266-47

RECEIVED
JAN 9 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Dr J H Wolverton

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00054

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke; LENGTH OF STAY (in this place) 50 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Pratt Street	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke; STREET ADDRESS (If rural, give location) Pratt Street

3. NAME OF DECEASED (Type or Print)	(First) JOHN	(Middle) WILLIAM	(Last) MAPHIS	4. DATE OF DEATH	(Month) January	(Day) 1	(Year) 19 50	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	November 30, 1891	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer helper	10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	11. BIRTHPLACE (State or foreign country) Romney, West Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob A Maphis		14. MOTHER'S MAIDEN NAME Fanny Shank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If year, give war or dates of service) WW I	16. SOCIAL SECURITY NO. 216-07-6013	17. INFORMANT AND ADDRESS Mrs Myrtle Maphis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage,	12hrs
442X 13/a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Schlerosis. and Hypertention.	
	(c) Cardio Renal Disesse.,	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1st, 1949, to Jan 1st, 1950, that I last saw the deceased alive on Dec 31st 49, and that death occurred at 7am m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
[signature]	Piedmont W Va.	1/3/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 4 1950	Ebenezer Cemetery	Romney, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 4/50	[signature]	E. S. Boal	Westernport, Maryland

442-11

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 5 1950
BUREAU V. S.

Within corporate limits DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

00055

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 29 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE PENNSYLVANIA COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HYNDMAN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ELIZABETH (Middle) (Last) MASON

4. DATE OF DEATH: (Month) JAN. (Day) 10 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: NOV. 27 1877

9. AGE last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND, Corriganville

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES HARDEN

14. MOTHER'S MAIDEN NAME: ELIZABETH BURKETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Arteriosclerotic Cardio-Vascular Renal Disease — Interval Between Onset and Death: 10 yrs.

442X

Antecedent cause(s)

13la Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to Jan 10, 1950, that I last saw the deceased alive on Jan 10, 1950, and that death occurred at 2:00 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title): John A Topper MD — ADDRESS: Hyndman Pa — DATE SIGNED: Jan 10, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 12, 1950	Hyndman Brethern Cem	Hyndman, Pennsylvania

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 11, 1950	Walter R. Hartz, M.D.	Harvey N. Zeigler	Hyndman, Pennsylvania

VS. A15

RECEIVED
JAN 17 1950
BUREAU V. S.

Within corporate limits

00056

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midlothian
STREET ADDRESS (If rural, give location): [redacted]

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) ---- (Last) McCutcheon

4. DATE OF DEATH: (Month) 1 (Day) 5 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Unknown

9. AGE last birthday: 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Garton, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown Samuel McCutcheon

14. MOTHER'S MAIDEN NAME: Anna Jacobs Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No | (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mr. Miller-Sylvan Retreat

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	6 wks
443 Antecedent cause(s)		
92d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive cardio vascular disease	4 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Jan 5, 1950, that I last saw the deceased alive on Jan 3, 1950, and that death occurred at 10:07 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Arthur F. Jones M.D. | 110 S. Centre St. | Jan. 6 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Jan. 7, 1950 | NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery | LOCATION (City, town, or county) (State): Moscow, Maryland

DATE REC'D BY LOCAL REG.: Jan. 6, 1950 | REGISTRAR'S SIGNATURE: Winter R. Krantz, M.D.

24. FUNERAL DIRECTOR: Boal | ADDRESS: Westernport, Md.

XVX99

RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits

00057

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Bowen St

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Girl (Last) McDonald

4. DATE OF DEATH (Month) Jan (Day) 23 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Jan 23, 1950
9. AGE last birthday yrs. If under 1 year Months. Days If under 24 hrs. Hours 3 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harold L. McDonald
14. MOTHER'S MAIDEN NAME Kathleen Neild

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Harold L. McDonald, Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Premature 30 wks.

776X

Antecedent cause(s)

159

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/23, 1950, to 1/23, 1950, that I last saw the deceased alive on Jan. 23, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Clay E. Furrett M.D. Cumberland 1/24/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1/24/50
NAME OF CEMETERY OR CREMATORY Ebenezer Meth Cemetery
LOCATION (City, town, or county) (State) Near Romney W. Va

DATE REC'D BY LOCAL REG. Jan. 24, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md.

2-0-1-23-0-20-2-32-R

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

Richard Williams

00058

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 801 The Dingle.

3. NAME OF DECEASED (Type or Print) (First) Adeline (Middle) (Last) McElfish
4. DATE OF DEATH (Month) Jan (Day) 1 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH April 17, 1870
9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Murley's Branch, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Isaac Chaney
14. MOTHER'S MAIDEN NAME Henrietta Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs Homer Whip 225 Balto Ave City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

443x

Antecedent cause(s)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive CVD — 3 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1/14/47, 19....., to 1/1/50, 19....., that I last saw the deceased alive on 1/1/50, 19....., and that death occurred at 10 00 P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
S. H. Williams M.D. Cumberland 1/3/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 4 1950
NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Jan. 3, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer Cumberland ADDRESS Md.

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 10 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 00059

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural near Mt. Savage
LENGTH OF STAY (In this place): 15 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Slabtown

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural) near Mt. Savage
STREET ADDRESS (If rural give location): Slabtown

3. NAME OF DECEASED (Type or Print): (First) Hannah (Middle) Elizabeth (Last) Mc Kenzie
4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1950

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: 3-1-1897
9. AGE last birthday: 52 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Wright
14. MOTHER'S MAIDEN NAME: Susan Beeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Ruth Tabler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 2nd.3rd.& 4th. degree burns of body.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Explosion & house burned.
(c)

916.0
180

INTERVAL BETWEEN ONSET AND DEATH: about 10 minutes.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home near (CITY OR TOWN) Mt. Savage (Slabtown) (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 18/50 12.30 A. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR?: Explosion & house burned.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, (undetermined ☒.* explosion origin.)

SIGNATURE (Degree or title): H.V.Deming M.D. H.V. Deming M.D.
ADDRESS: Cumberland Md.
DATE SIGNED: Jan.18-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 1-20-50
NAME OF CEMETERY OR CREMATORY: Porter Cemtery
LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG.: 1-20-50
REGISTRAR'S SIGNATURE: Dan Haney N. Roe
24. FUNERAL DIRECTOR: J. R. Durst,
ADDRESS: Frostburg, Md.

VS. A15A

RECEIVED
JAN 25 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00660

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 4 Altamont Terrace

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) Elizabeth (Last) Mears

4. DATE OF DEATH: (Month) 1 (Day) 9 (Year) 19 50

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W

8. DATE OF BIRTH: Apr. 9, 1872

9. AGE last birthday: 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John B. Reese

14. MOTHER'S MAIDEN NAME: Margaret Frances

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Joseph Fisher 454 Balto. Ave. Cumb.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a)	Cerebral Vascular Accident	6 days
331 X Antecedent cause(s)			
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	General Arteriosclerosis	4 yrs.
	(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 46, to Jan 8, 1950, that I last saw the deceased alive on Jan 7, 1950, and that death occurred at Jan 9 12:15 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. Jan. 9 1950

23. BURIAL, CREMATION / REMOVAL (Specify) Burial DATE Jan. 11, 1950 NAME OF CEMETERY OR CREMATORY Allegany Cem. LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. Jan. 11, 1950 REGISTRAR'S SIGNATURE Wirter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.

RECEIVED
JAN 17 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00661

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STATE MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 439 Pine Ave

3. NAME OF DECEASED (Type or Print): (First) Violet (Middle) Virginia (Last) Meekins

4. DATE OF DEATH: (Month) Jan (Day) 8 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Black

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: March 4, 1907

9. AGE last birthday: 42 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Perry Scott Sr

14. MOTHER'S MAIDEN NAME: Cora Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Chas Perry Scott Jr 310 Md Ave Cities

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute coronary occlusion — Interval Between Onset and Death: 1/2 hour

420.0

Antecedent cause(s)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) congestive heart failure — 2 weeks

(c) arteriosclerotic heart disease — 1 year

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-, 1950, to 1-8, 1950, that I last saw the deceased alive on 1-8, 1950, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE L Dennis (Degree or title) MD ADDRESS 57 Green St. DATE SIGNED 1-10-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Jan 11, 1950 — NAME OF CEMETERY OR CREMATORY: Summer Cemetery — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Jan. 11, 1950 — REGISTRAR'S SIGNATURE: Walter K. Dantz M.D.

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland Md

RECEIVED
JAN 17 1950
BUREAU V. S.

Evidence for addition in #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00062

CERTIFICATE OF DEATH

FILM No. G 124 FEB 14 1950

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shaft
STREET ADDRESS (If rural, give location) R. L. No. 1, Frostburg, Md.

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) Bell (Last) Miller

4. DATE OF DEATH (Month) 1 (Day) 19 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Feb. 28-1873
9. AGE last birthday 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. C.

13. FATHER'S NAME Michael Muir
14. MOTHER'S MAIDEN NAME Jennie Telford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Mr Clarence Miller R. L. No. 1 Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
4500	Immediate cause	(a) Pneumonia lobar - a terminal condition. (2-14-50 ams.)	5 days
108	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis, Heart failure	10 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-13, 1950, to 1-19, 1950, that I last saw the deceased alive on 1-18, 1950, and that death occurred at 4 30 a.m., from the causes and on the date stated above.

SIGNATURE L. L. Wolferman (Degree or title) M.D. ADDRESS Frostburg DATE SIGNED 1-19-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-22-1950
NAME OF CEMETERY OR CREMATORY Allegany Cem.
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 1-20-50
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00663

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 14 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg Md.
STREET ADDRESS (If rural, give location): Carlos R. D. No I

3. NAME OF DECEASED (Type or Print): (First) Ezra (Middle) Ace (Last) Morgan

4. DATE OF DEATH: (Month) I (Day) 15 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 3-6-1919

9. AGE last birthday: 30 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Textile Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Carlos, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Morgan

14. MOTHER'S MAIDEN NAME: Carrie Speir

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): World 2

16. SOCIAL SECURITY NO.: 217-10-5970

17. INFORMANT AND ADDRESS: Mrs Carrie Morgan. R. D. No I Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Nephritis — Interval Between Onset and Death: 15 Days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c) Diabetes — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1950, to Jan 15, 1950, that I last saw the deceased alive on Jan 15, 1950, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

SIGNATURE: Wm C Lane (Degree or title) M.D. ADDRESS: Frostburg Md DATE SIGNED: 1-16-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 1-18-1950 — NAME OF CEMETERY OR CREMATORY: Allegan Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 1-18-50 — REGISTRAR'S SIGNATURE: Mrs Nancy N. Rose

24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md.

VS. A15

Wm C Lane

V22-16

RECEIVED
JAN 21 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

00664

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
STREET ADDRESS (If rural, give location): School St. LaVale

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) (Last) Morrill

4. DATE OF DEATH: (Month) Jan. (Day) 22, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Aug. 21, 1866

9. AGE last birthday: 83 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Warner, New Hampshire

12. CITIZEN OF WHAT COUNTRY?: U.S

13. FATHER'S NAME: Joel Cushon

14. MOTHER'S MAIDEN NAME: Emily Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. James Walker Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	10 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) coronary sclerosis, previous occlusion	7 yrs.
	(c) old age	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to Jan 22, 1950, that I last saw the deceased alive on 1/21, 1950, and that death occurred at 945A m., from the causes and on the date stated above.

SIGNATURE: Elizabeth Boyer, M.D. (Degree or title) ADDRESS: 55 Greene St. DATE SIGNED: 1/22/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 1-25-1950

NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

LOCATION (City, town, or county) (State): Penacook, N.H.

DATE REC'D BY LOCAL REG.: Jan 23, 1950

REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

RECEIVED
JAN 31 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00065

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg, Route 1
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) CATHERINE (Last) MUNSIE
4. DATE OF DEATH: (Month) Jan. (Day) 12, (Year) 1950
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed
8. DATE OF BIRTH: 12-12-1864
9. AGE last birthday: 85 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Rawlings, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry C. Cook
14. MOTHER'S MAIDEN NAME: Lydia Ann Spencer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mrs. Clarence Powers, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fracture Left Femur (accidental) — Jan 8 1950

903.0 Antecedent cause(s)

186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteria Sclerosis — many years

(c) Senile Dementia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home
(CITY OR TOWN): Frostburg (COUNTY): Alleg (STATE): Md
TIME OF INJURY (Month) (Day) (Year) (Hour): Jan 8 1950 2 P.M.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? Fell in hallway at home

22. I hereby certify that I attended the deceased from Jan 9, 1950, to Jan 12, 1950, that I last saw the deceased alive on Jan 12, 1950, and that death occurred at 5 00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W O M Lane M D — ADDRESS: Frostburg Md — DATE SIGNED: Jan 13 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1-15-50 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 1-15-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy K Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. — ADDRESS

RECEIVED
JAN 18 1950
BUREAU P. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00666

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 5 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 134 Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 134 Main

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Terrance (Last) Murphy

4. DATE OF DEATH: (Month) Jan. (Day) 16, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: June 9, 1863

9. AGE last birthday: 86 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Clerk in Oil Shop, B. & O. Ry. Co

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Keyser, W. Va.

12. CITIZEN OF WHAT COUNTRY? U-Sa

13. FATHER'S NAME: Patrick Murphy

14. MOTHER'S MAIDEN NAME: Hannah Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Mrs. Thos. V. McGuire

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Edema	1 Day
422.2 Antecedent cause(s)	Chronic Myocarditis and Myocardial Degeneration	
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Not Specified as Rheumatic	5 Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 10, 1947, to Jan. 16, 1950, that I last saw the deceased alive on Jan. 13, 1950, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

SIGNATURE: David S. Wilson (Degree or title): M.D. ADDRESS: Piedmont, W. Va. DATE SIGNED: Jan. 17, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE: 1/18/50; NAME OF CEMETERY OR CREMATORY: St. Thomas; LOCATION (City, town, or county) (State): Keyser, W. Va.

DATE REC'D BY LOCAL REG.: 1/18/50; REGISTRAR'S SIGNATURE: [illegible] MD

24. FUNERAL DIRECTOR: B. H. Markwood; ADDRESS: Keyser, W. Va.

266-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00067

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Linden Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 61 Linden Street

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	George	Calvin	Myers		1	30th	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	May 15th, 1876	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Shovel Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Myers
14. MOTHER'S MAIDEN NAME: Ellen Imler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No.
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Cora J. Myers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) acute Congestive Heart failure — Interval between onset and death: 12 hrs.

1410x

Antecedent cause(s)

92a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension & aortic & mitral insufficiency years.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 Jan, 1950, to 30 Jan, 1950, that I last saw the deceased alive on 30 Jan, 1950, and that death occurred at 3.30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John B. Davies	M.D.	Frostburg. Md.	1/30/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/3/50.	Allegany [illegible]	Frostburg	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-31-50	Mrs Nancy K Roe	Jacob Nafe	23 E. Main, Frostburg Md.

358-99

RECEIVED
FEB 3 1950
BUREAU V. R.

DR. SIMONS

Within corporate limits 1454

00068

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. | LENGTH OF STAY (in this place) 1 DAY

HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near CUMBERLAND, ~~MARYLAND~~ Rural

STREET ADDRESS (If rural, give location) ROUTE #4, BOX 210

3. NAME OF DECEASED (Type or Print) (First) ADDIE (Middle) M. (Last) NEWCOMB

4. DATE OF DEATH (Month) 1- (Day) 23- (Year) 50 19

5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH NOV. 24, 1899 | 9. AGE last birthday 50 yrs. | If under 1 year Months. Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES C. NEWCOMB | 14. MOTHER'S MAIDEN NAME LORENA TEETERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebro vascular accident	36 hrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	6 yrs
	(c)	

33x

83a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21, 1950, to 1/23, 1950, that I last saw the deceased alive on 1/23, 1950, and that death occurred at 3:10 P.m., from the causes and on the date stated above.

SIGNATURE George M Simons (Degree or title) MD. ADDRESS 128 Union St Cumberland Md. DATE SIGNED 1/23/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 1/26/1950 | NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park | LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. Jan. 25, 1950 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

I

RECEIVED
JAN 31 1950
BUREAU V. S.

Parry-

00.69

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midlothian
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) ~~Parry~~ Frank (Middle) Parry (Last) ~~Frank~~

4. DATE OF DEATH: (Month) Jan (Day) 16 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 14, 1876

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sameul Parry

14. MOTHER'S MAIDEN NAME: Ellen Bosley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Raymond Eichhorn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary Thrombosis — 24 hrs

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Bronchial Asthma

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/15, 1950, to 1/16, 1950, that I last saw the deceased alive on 1/16, 1950, and that death occurred at 1 pm. m., from the causes and on the date stated above.

SIGNATURE: Hilla Jansbaltby (Degree or title) M.D. ADDRESS: Frostburg Md DATE SIGNED: 1/17/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan 20, 1950
NAME OF CEMETERY OR CREMATORY: Allegany Cemetery
LOCATION (City, town, or county) (State): Frostburg Md

DATE REC'D BY LOCAL REG. 1-20-50
REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe

24. FUNERAL DIRECTOR: M. Eichhorn
ADDRESS: Lonaconing, Md

454.42

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1950
BUREAU V. S.

Evidence for addition on #18 shown on:

Dr Gattens

00070

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

FILM No. G 1 24 FEB 14 1950

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midlothian
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midlothian
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) COWAN (Last) PEARCE

4. DATE OF DEATH (Month) Jan. (Day) 2, (Year) 1950

5. SEX Male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH 9-25-1854

9. AGE last birthday 95 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Pearce

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY No. none

17. INFORMANT AND ADDRESS Mrs. Blaine Willetts, Midlothian, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypostatic Congestion lungs; developed 7 days.

522X Antecedent cause(s) following bed confinement, due to progressive weakness.

111c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Apparently no infectious process. (2-14-50- ams.)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 28, 1949, to Jan 2, 1950, that I last saw the deceased alive on Jan 1, 1950, and that death occurred at 10:00 P m. from the causes and on the date stated above.

SIGNATURE W E Gattens (Degree or title) M.D. ADDRESS Frostburg Md. DATE SIGNED 1/4/50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 1-4-50 NAME OF CEMETERY OR CREMATORY Allegany Cemetery LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. 1-5-50 REGISTRAR'S SIGNATURE Mrs Nancy H. Roe

24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md. ADDRESS

302-85

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JAN 10 1950
BUREAU V. S.

Outside of City limits

00071

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Alegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland, Rural
LENGTH OF STAY (in this place): 0
HOSPITAL OR INSTITUTION OR STREET ADDRESS: In route to the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crellin
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joyce	Claudett	Pike	Jan.	26	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	single	Aug. 24-1949	0 yrs.	5			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Crellin Md. W. Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Rodney Pike	Virginia Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Rodney Pike

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
491x Immediate cause	(a) Bronchopneumonia	3 days
107 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under lying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland Md.	Jan.27-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/28/1950	Sines Cemetery	Sines, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 28, 1950	Walter R. Frantz, M.D.	Emroy D. Bolden, Oakland, Md.	

9-R-8-24-9-00-0-00-R-

VS-A15A

XVX99

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

Weisman

00072

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 321 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Alleg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 321 Bedford St

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) Guin (Last) Piatt

4. DATE OF DEATH (Month) Jan. (Day) 25 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 21 - 1869
9. AGE last birthday 80 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New Columbus, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Marian Elizabeth Dixon 321 Bedford St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.0	Immediate cause	(a) myocardial infarction	1/2 hours
	Antecedent cause(s)		
93d	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary arteriosclerosis + insufficiency	10 years
		(c) Arteriosclerotic heart disease with	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bundle branch and auriculo ventricular block

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) no (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) no m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ no
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from May, 1948, to Jan 25, 1950, that I last saw the deceased alive on Jan 25, 1950, and that death occurred at 3 45 P.m., from the causes and on the date stated above.

SIGNATURE Saville G. Weisman (Degree or title) MD ADDRESS 122 Bedford St Cumberland, Md DATE SIGNED 1/26/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan. 28/50
NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery
LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Jan. 27, 1950
REGISTRAR'S SIGNATURE Winter R. Frank, M.D.
24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

740-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 31 1950
BUREAU V. S.

Dr. McLane

00673

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 155 Center St.

3. NAME OF DECEASED (Type or Print): (First) HANNAH (Middle) (Last) POWELL

4. DATE OF DEATH: (Month) Jan. (Day) 30, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 3-20-1888

9. AGE last birthday: 61 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Lloyd

14. MOTHER'S MAIDEN NAME: Margaret Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: David Powell, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: 2 Days

331 Antecedent cause(s)

53a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — Interval between onset and death: Several years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 28, 1950, to Jan. 30, 1950, that I last saw the deceased alive on Jan. 30, 1950, and that death occurred at 1:35 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. McLane MD — ADDRESS: Frostburg Md — DATE SIGNED: 1-30-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-2-50 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 2-2-50 — REGISTRAR'S SIGNATURE: Miss Nancy H. Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. — ADDRESS

RECEIVED
FEB 7 1950
BUREAU V. S.

Evidence for change of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00074

FILM No. G 1 23 JAN 17 195

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Little Orleans
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Little Orleans
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Viola	E.	Price	Jan.	4	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
female	White	Married	5-6-~~18~~1891	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	—	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Barnes	Jane Bishop

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
—	—	—	William H. Price - (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Metastasis

Immediate cause (a) Carcinoma of R. Lung including Trachea — about 2 mo

171x **Antecedent cause(s)**

48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Pancreas — over 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1/1/50, 19..... to 1/4/50, 19....., that I last saw the deceased alive on 1/4/50, 19....., and that death occurred at 8.53 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) H. E. Tabler M.D. — ADDRESS Hancock Md. — DATE SIGNED 1/6/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1-7-50	Piney Plains Meth. Cem.	Allegany	Md.

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/6/50	Mrs. J. A. Watson, Deputy	Charles R. Bast	Hancock, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 12 1950
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

00075

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 50 Years
~~HOSPITAL OR INSTITUTION OR~~ STREET ADDRESS ~~Allegany~~ 11 Browning Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 11 Browning Street

3. NAME OF DECEASED (Type or Print) (First) Jay (Middle) D (Last) Ranck

4. DATE OF DEATH (Month) Jan (Day) 20 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Oct 9 1866

9. AGE last birthday 83 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Bldg Houses

11. BIRTHPLACE (State or foreign country) Three Springs, Penna

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Philip Ranck

14. MOTHER'S MAIDEN NAME Lucinda Bucher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Miss Gerdrude Ranck 11 Browning St Cumberland, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	3 yrs.
Antecedent cause(s)	(b) Arterio Sclerosis	10 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

422.1

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1940, to Jan. 20, 1950, that I last saw the deceased alive on Jan 20, 1950, and that death occurred at 9 15/1 m., from the causes and on the date stated above.

SIGNATURE H. W. Eleason MD (Degree or title) ADDRESS 126 Union St Cumberland Md DATE SIGNED 1/21/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Jan. 24 1950 NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery LOCATION (City, town, or county) Warfordsburg, Penna (State)

DATE REC'D BY LOCAL REG. Jan. 23, 1950 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

308 Y9

RECEIVED
JAN. 25 1950
BUREAU V. S.

Dr. Wolferman
00078

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15 T

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 91 Pine St.

3. NAME OF DECEASED (Type or Print): (First) CONRAD (Middle) (Last) RASE
4. DATE OF DEATH: (Month) Jan. (Day) 20, (Year) 1950

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 9-18-1876
9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired miner
10b. KIND OF BUSINESS OR INDUSTRY: Coal mines
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Justus Rase
14. MOTHER'S MAIDEN NAME: Elizabeth Deal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Margaret Rase, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Broncho-Pneumonia, heart failure — 2 weeks

523.0 Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Silicosis, Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1949, to Jan 20, 1950, that I last saw the deceased alive on Jan. 20, 1950, and that death occurred at 6 10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Dr. [illegible] Wolferman M.D.
ADDRESS: Frostburg Md
DATE SIGNED: 1-23-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 1-23-50
NAME OF CEMETERY OR CREMATORY: Allegany Cemetery
LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REG. 1-23-50
REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR: J. R. Durst,
ADDRESS: Frostburg, Md.

454 V2

RECEIVED
JAN 30 1950
BUREAU V. S.

DR. HALLINAN

Within corporate limits

00077

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 25 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MT. SAVAGE
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): Bald Knob.

3. NAME OF DECEASED (Type or Print)	(First) CORA	(Middle)	(Last) RAWLINGS	4. DATE OF DEATH	(Month) JAN.	(Day) 22,	(Year) 50
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW	8. DATE OF BIRTH: NOV. 28, 1875	9. AGE last birthday: 74 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA.				
13. FATHER'S NAME: ELIJAH RAWLINGS	14. MOTHER'S MAIDEN NAME: ESTHER A. WELSH						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.0	Immediate cause	(a) Cerebral Hemorrhage	15 da.
	Antecedent cause(s)		
93d	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart Disease	
		(c) Generalized arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Advanced age

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 Dec., 1949, to Jan. 22, 1950, that I last saw the deceased alive on Jan. 22, 1950, and that death occurred at 4.45 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James P. Hallinan M.D.		Top Decatur St. Cumberland Md.	1-23-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Bureal	Jan. 25, 1950	Vale Summit Cemetery	Vale Summit, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 24, 1950	Hunter R. Frantz, M.D.	J. R. Hurst, Frostburg, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

I

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00678

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 5 Beall Street

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) (Last) Rogers

4. DATE OF DEATH: (Month) 1 (Day) 6 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 10-2-76

9. AGE last birthday: 73 yrs. — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Borden Shaft, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Brode

14. MOTHER'S MAIDEN NAME: Elizabeth Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Allegany County Infirmary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332 x **Immediate cause** (a) Cerebral Thrombosis — Interval Between Onset and Death: 1 mo.

83 b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General Arteriosclerosis — 5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Jan. 27, 1949, to Jan. 6, 1950, that I last saw the deceased alive on Jan. 6, 1950, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur F. Jones M.D. — **ADDRESS**: 110 S. Centre St. — **DATE SIGNED**: Jan. 7, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE**: Jan. 9, 1950 — **NAME OF CEMETERY OR CREMATORY**: Allegany Cemetery — **LOCATION** (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REG.: Jan. 9, 1950 — **REGISTRAR'S SIGNATURE**: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: Hafer's — **ADDRESS**: Frostburg, Md.

RECEIVED
JAN 13 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Schindler

00079

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 476½ Baltimore Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ruth	Mae	Roland	Jan	6	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	Married	Sept. 23, 1906	43 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Edward Sabin
14. MOTHER'S MAIDEN NAME: Makenawl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-28-0148
17. INFORMANT AND ADDRESS: Mrs Virgie Greenawalt, 917 Md Ave Cbld

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442x **Immediate cause** (a) Uremia — 2 months

Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension C.V. Renal Disease — years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1949, to Jan., 1950, that I last saw the deceased alive on Jan. 6, 1950, and that death occurred at 7:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B. M. Schindler M.D. 41 Bennett St., Cumberland, Md. Jan 7/1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 8, 1950	Mt. Hope Christian Cem.	Near Flintstone Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 8, 1950	Walter K. Mantz, M.D.	John J. Hafer Cumberland Md

RECEIVED
JAN 17 1950
BUREAU V. B.

Within corporate limits

00080

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 503 Fayette St

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) Valentine (Last) Ruppert
4. DATE OF DEATH (Month) Jan (Day) 2 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Aug 4 1869
9. AGE last birthday 80 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brew Master retired
10b. KIND OF BUSINESS OR INDUSTRY Brewery
11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Ruppert
14. MOTHER'S MAIDEN NAME Mary Ann Roberick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 220-03-7603
17. INFORMANT AND ADDRESS Mrs Ann Straub Ruppert

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) Arteriosclerotic heart disease with cardiac failure — 3 mos.

Antecedent cause(s) (b) Generalized arteriosclerosis — Do not know.

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 31, 1949, to Jan. 2, 1950, that I last saw the deceased alive on Jan. 1, 1950, and that death occurred at 3 15 A m., from the causes and on the date stated above.

SIGNATURE W. Alfred Van Ome (Degree or title) M.D. ADDRESS 531 Louisiana Ave. Cumberland, Md. DATE SIGNED Jan. 4, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 4 50
NAME OF CEMETERY OR CREMATORY St Peter + Pauls Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Jan. 4, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS " "

496 X0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits

Dr. Fo[illegible]

00081

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 437 Pine Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 437 Pine Ave.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Elizabeth (Last) Simms

4. DATE OF DEATH (Month) Jan (Day) 4 (Year) 1950

5. SEX Female
6. COLOR OR RACE Black
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 19, 1870
9. AGE last birthday 79 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hancock Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Yonker
14. MOTHER'S MAIDEN NAME Anna Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Thomas Simms, Braddock Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Bronchitis — Interval Between Onset and Death: One week

422.2 Antecedent cause(s)

93e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocarditis — Not known

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1-3, 1950, to 1-4, 1950, that I last saw the deceased alive on 1-3, 1950, and that death occurred at 12 55 P m., from the causes and on the date stated above.

SIGNATURE James T. Johnson (Degree or title) ADDRESS Jr. M.D. Cumberland Md DATE SIGNED 1-6-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 7, 1950
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Jan 7, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
JAN 10 1950
BUREAU V. S.

Within corporate limits.

Dyer

MARYLAND STATE DEPARTMENT OF HEALTH

00682

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STATE: MARYLAND
LENGTH OF STAY (in this place): 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 39 Mary St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 36 Mary St.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) William H.S. (Last) Sisk

4. DATE OF DEATH: (Month) January (Day) 31 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: June 9, 1872

9. AGE last birthday: 77 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive engineer

10b. KIND OF BUSINESS OR INDUSTRY: B & O R.R.

11. BIRTHPLACE (State or foreign country): Claysville, W. Va

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Sisk

14. MOTHER'S MAIDEN NAME: Harriett Fetters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: William H. Sisk, 38 Mary St. Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	1 hr
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary insufficiency	Several mos. (8-9)
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Jan 31, 1950, to —, 19....., that I last saw the deceased alive on Jan 31, 1950, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): John A. Dyer, M.D. ADDRESS: 247 Va Ave. DATE SIGNED: 2-3-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Febr 8, 1950
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: 2-3-50
REGISTRAR'S SIGNATURE: Hunter R. Crosby, M.D.
24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, Md. ADDRESS:

322-47

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00683

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MD.; COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 7-DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: HUTTON
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEON	R.	SISLER	JAN. 16 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
MALE	WHITE	MARRIED	MARCH 20 1920	29 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE - Carpenter		W.VA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HENRY A. SISLER	BERDIE M. NEWBRAUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowo) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Pyelonephritis with uremia	
962.0 Antecedent cause(s)	Chronic cystitis & fecal calculi	
186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Paralysis	
	(c) Traumatic injury of spinal cord.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
✓	✓	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	✓	Ellicott City	Md.	

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR?
October 17 1943 m.		Fell about 10 feet, landing on back

22. I hereby certify that I attended the deceased from Jan 9, 19 50, to Jan 16, 19 50, that I last saw the deceased alive on 1-15-, 19 50, and that death occurred at 6:44A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Howard L. Tolson, M.D.	Cumberland Md.	1-17-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 19 1950	Oakland Cemetery	Oakland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 18, 1950	Wrute R. Kantz, M.D.	Ensor & Bolden	Oakland Md

308 V9

RECEIVED
JAN 24 1950
BUREAU V. S.

Write in corporate limits Rec'd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00085

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Rhode Island COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newport
STREET ADDRESS (If rural, give location) 11 Whitwell Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	William	Spence	January	12	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	Widowed	July 27, 1885	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
C.P.O.	U.S. Navy	Newport, R.I.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Spence	Mary Regan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
Yes	Wor 1901-1930	—	Mrs. James Irons, Newport, R.I.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
331 Immediate cause	(a) Coronary thrombosis	1 hour
Antecedent cause(s)	(b) Arteriosclerosis	Unknown
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 19 50 to Jan 12, 19 50, that I last saw the deceased alive on Jan 12, 19 50, and that death occurred at 6:35 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jan 13 50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 16, 1950	Todd Cemetery	New Port, R.I.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 13, 1950	Wynter R. Hank, M.D.	John J. Hafer	Cumberland Md.

460-96

RECEIVED
JAN 17 1950
BUREAU V. S.

Within corporate limits

DR. MURRAY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00084

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2-DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, Rural
STREET ADDRESS (If rural, give location): BOWMAN'S ADDITION

3. NAME OF DECEASED (Type or Print): (First) BABY GIRL (Middle) (Last) SPENCER

4. DATE OF DEATH: (Month) JAN. (Day) 11 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): INFANT

8. DATE OF BIRTH: JAN. 9 1950

9. AGE last birthday: yrs. | If under 1 year: Months. | Days 2 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LORENZO SPENCER, JR

14. MOTHER'S MAIDEN NAME: WANDA L. ATKINSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Viola Timbrook - Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Premature 6½ mos infant — Interval between onset and death:

776 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 9, 1950 to Jan 11, 1950, that I last saw the deceased alive on Jan 10, 1950, and that death occurred at 6:40 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Allan E. Murray M.D. Cumberland Md Jan 12 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 1/13/50 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: Jan 13, 1950 | REGISTRAR'S SIGNATURE: Winter R. Hardy, M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hofer Cumberland, Md

2-0-1-09-0-23-5-26-2

XVX 99

RECEIVED
JAN 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 00086

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural- in ambulance, east of
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Frostburg Md. in route to Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural near Grantsville
STREET ADDRESS (If rural give location): R.F.D.2 ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ray	Junior	Spiker	Jan.	17	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	White	Single	Sept. 20-1929	20 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Co. near Grantsville, Garrett
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gurney Spiker
14. MOTHER'S MAIDEN NAME: Dessie Pearce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-24-8092
17. INFORMANT: Father

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intra-abdominal hemorrhage due to a	1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) crushed pelvis & fractured spine, lumbar region.	
	(c)	

910.1
175c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: farm near home	(CITY OR TOWN): 3 miles east of Grantsville	(COUNTY): Garrett	(STATE): Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY: Jan. 17/50 P. m.	INJURY OCCURRED While at work ☒ Not while at work ☐	HOW DID INJURY OCCUR? Cutting down tree & it fell in the wrong direction.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	Jan. 17-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 20, 1950	Grantsville Cemetery	Grantsville, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-19-50	Mrs. Nancy N. Roe	Wm. Winterberg, Grantsville,	"

958-99

RECEIVED
JAN 21 1950
BUREAU V. S.

Within corporate limits DR. SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

00687

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 7 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
STREET ADDRESS (If rural, give location): OVER HAMMERSMITH REST. QUEEN CITY PAVEMENT

3. NAME OF DECEASED (Type or Print): (First) HOWARD — (Middle) T — (Last) SWISHER

4. DATE OF DEATH: (Month) JAN. (Day) 30 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: JUNE 27 1909

9. AGE last birthday: 41 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S. of AMERICA

13. FATHER'S NAME: TAYLOR SWISHER

14. MOTHER'S MAIDEN NAME: NETTIE SWISHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-05-9099

17. INFORMANT AND ADDRESS: Taylor P Swisher Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Cerebro - vascular accident — Interval Between Onset and Death: 5 days

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b): Hypertension
(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/2/50, 19..., to 1/30, 19..., that I last saw the deceased alive on 1/30, 19..., and that death occurred at 11:30 P.m., from the causes and on the date stated above.

SIGNATURE: George M Swisher M.D. — (Degree or title) — ADDRESS: 128 Decatur St. Cumberland — DATE SIGNED: 1/30/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-2-1950 — NAME OF CEMETERY OR CREMATORY: Zion Memorial Park — LOCATION (City, town, or county): Cumberland — (State): Md.

DATE REC'D BY LOCAL REG.: Feb 2, 1950 — REGISTRAR'S SIGNATURE: Hunter L. Crouse M.D.

24. FUNERAL DIRECTOR: Louis Stein, Inc. — ADDRESS: Cumberland

458-44

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FEB 7 1950
BUREAU V. S.

DR. SCHINDLER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

60688

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 31 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 218 PARK STREET

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DAVID		TAYLOR	JAN.	28	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	WHITE	WIDOWER	OCT. 19, 1872	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED		WEST VIRGINIA	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN TAYLOR	ELIZABETH TEETS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	?	MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Generalized arteriosclerosis	6 months
450.0 Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility	6 months
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 26, 1948, to Jan. 28, 1950, that I last saw the deceased alive on Jan. 27, 1950, and that death occurred at 3:53 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
B. M. Schindler M.D.	41 Greene St, Cumberland, Md.	Jan 28/1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal & Burial	Jan. 30. 50	Terra alta, Cemetery	Terra alta. W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 29, 1950	Wenter K. Kantz M.D.	A. F. Collins. Terra alta. W.Va.	

XVX99

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

00089

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1/5 mile inside City limits R.F.D.3 Valley Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland Rural
STREET ADDRESS (If rural give location): R.F.D.#3 Valley Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Abraham	Byron	Teter	Jan.	9	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	widower	Aug. 31-1885	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	cutting timber	Circleville Pendleton Co. W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Alfred Teter	Cordandia Jordan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.		Son) Bryon Teter & Mrs. John Berry

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Intra-abdominal hemorrhage due to a fractured	about 8
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) spine, also had a subdural hemorrhage.	minutes.
(c) Pedestrian, hit by an automobile.	

812.5
170 C

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: highway — (CITY OR TOWN): Valley Road Cumberland — (COUNTY): Allegany — (STATE): Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY: Jan. 9/50-5.52 P m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Walking with traffic and hit by an Automobile.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.	Cumberland Md.	Jan. 9-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-12-1950	Teter Cemetery	Bowmans Addition Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 12, 1950	Winter R. Kantz. M.D.	John J. Hafer, Cumberland Md.

788-08

RECEIVED
JAN 17 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00690

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 60yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 311 Lang Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joseph	W.	Thorpe	I/23/50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	Married	2/14/1869	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Engineer	B&ORR	Hampshire County W.Va.	USA.

13. FATHER'S NAME: Wm. Braxton Thorpe
14. MOTHER'S MAIDEN NAME: Susie Ruckman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		705-07-6884	Mrs Lolya Comer 311 Lang Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

600.0 **Immediate cause** (a) Pyelonephritis — 4 mo

133a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Urinary retention
(c) Supra pubic drainage — 4 mo

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 30, 1949, to Jan. 23, 1950, that I last saw the deceased alive on Jan. 22, 1950, and that death occurred at 2 15 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS — DATE SIGNED

Arthur F. Jones M.D. — 1102 Centre St. — Jan. 23, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	I/25/50	Rose Hill Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
Jan. 24, 1950	Winter R. Frantz, M.D.	James F. Scarpelli Cumberland, Md.

322-47

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

00091

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 73 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 211 CENTRAL AVE.,

3. NAME OF DECEASED (Type or Print): (First) JOHN J. (Middle) (Last) TREIBER SR.

4. DATE OF DEATH: (Month) JANUARY (Day) 8 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: JULY 15, 1876

9. AGE last birthday: 73 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: City of Cumberland

11. BIRTHPLACE (State or foreign country): ASSIST. CHIEF-POLICE MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHARLES E. TREIBER

14. MOTHER'S MAIDEN NAME: MOLLIE ALBRIGHT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: John J Treiber Jr. Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Intestinal hemorrhage, severe, cause undetermined	Jan. 8, 1950
Antecedent cause(s)	(a) Perforated duodenal ulcer	Onset Dec. 25, 1949
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary heart disease with ant. coronary occlusion	Dec. 17, 1949
	(c) Sub-acute bronchitis, purulent.	14 Nov., 49

541.1
117 b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Dec. 25, 1949

19b. MAJOR FINDINGS OF OPERATION: Perforated duodenal ulcer.

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 Jan., 1947, to Jan. 8, 1950, that I last saw the deceased alive on Jan. 8, 1950, and that death occurred at 11:35 P. M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. Alfred Van Ormer M.D.
ADDRESS: 531 Louisiana Ave. Cumb., Md.
DATE SIGNED: Jan. 9, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan 11 50	Greenmount Cemt	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 10, 1950	Walter L. Mantz, M.D.	Louis Stein Inc	" "

10498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 17 1950
BUREAU V. S.

Dr. Moseley

00092

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) MARY	(Middle) JANE	(Last) UHL	4. DATE OF DEATH	(Month) Jan. (Day) 3, (Year) 1950
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 12-29-1865	9. AGE last birthday 84 yrs.	If under 1 year Months, Days; If under 24 hrs. Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Carter	14. MOTHER'S MAIDEN NAME Roseann McKenzie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No. none	17. INFORMANT AND ADDRESS John Uhl, Mt. Savage, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Insufficiency - following	2 weeks -
900.9 Antecedent cause(s)	(b) Shock from a fall down stairs -	2 weeks -
186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Senility (especially Mental)	10 years -

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) Acc.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 1949 m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-12, 1949, to 1-3, 1950, that I last saw the deceased alive on 1-3, 1950, and that death occurred at 4:00 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William E. Moseley	M.D.	Mt Savage, Md.	1-4-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1-7-50	NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery	LOCATION (City, town, or county) (State) Mt. Savage, Md.
DATE REC'D BY LOCAL REG. 1-6-50	REGISTRAR'S SIGNATURE Veronica McDermott	24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 9 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00093

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural near Mornantown; MARYLAND LENGTH OF STAY (In this place): 13 hrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart; STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Neill	Villi	Jan.	18	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	white	widower	April 27-1886	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired miner	Coal mines	Indianna Pa.	?

13. FATHER'S NAME: Micheal Villi

14. MOTHER'S MAIDEN NAME: Marie Marincak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	213-09-6426	Son) Charles Villi

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute cardiac failure due to coronary	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) occlusion & coronary sclerosis also had	?
(c) small peripancreatic hemorrhage.	about 13 hours.

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work [ ] Not while at work [ ]	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: naturol causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland Md.	Jan.18-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-21-1950	St. Michaels Cem.	Frostburg, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-20-50	Mrs. Hazel K. Roe	Jacob Hafer	Frostburg, Md

45402

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 25 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

00094

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 10 yrs; MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 128 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural give location): 128 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Mabel (Middle) V. (Last) McKenzie Wagner

4. DATE OF DEATH: (Month) Jan. (Day) 17 (Year) 19 50

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Dec. 3 1905

9. AGE last birthday: 44 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Barnum W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Horace R. Mc Kenzie

14. MOTHER'S MAIDEN NAME: Martha Lucy Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 217-10-1911

17. INFORMANT: Thomas Wagner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) coronary sclerosis	?
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Jan. 17-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Jan 19 1950

NAME OF CEMETERY OR CREMATORY: Rose Hill Cem

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Jan. 19, 1950

REGISTRAR'S SIGNATURE: Wister R. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc.

ADDRESS: Cumberland Md

RECEIVED
JAN 24 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00095

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): One Day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 1407 Bedford Street

3. NAME OF DECEASED (Type or Print)	(First) Carol	(Middle) Ruth	(Last) Webster	4. DATE OF DEATH	(Month) Jan (Day) 10 (Year) 50
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Jan 9 1950	9. AGE last birthday: yrs.	If under 1 year: Months. Days: One; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): No	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Cumberland, Allegany CoMd,	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: James W. Webster, Jr.	14. MOTHER'S MAIDEN NAME: Sarah Ruth Yommer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: Jas W. Webster 1407 Bedford St Cumberland, Maryland			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Respiratory failure - Central Nervous System damage	24 hrs
761.5 Antecedent cause(s)		
160c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Prematurity & Breech extraction	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 ~~10~~ Jan, 1950, to 10 ~~11~~ Jan, 1950, that I last saw the deceased alive on 10 Jan, 1950, and that death occurred at 3:00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Leland B Ransom	MD	63 Greene St	12 Jan 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Jan 12 1950	NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: Jan. 12, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.	ADDRESS

2-0-1-09-0-21-1-32-3

XV 99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr Ransom

DR. GRACIE

Hafer 65

00096

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 15 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DEER PARK
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) EMILY	(Middle) GRACE	(Last) WHITE	4. DATE OF DEATH	(Month) 1-27-50 (Day) (Year) 19
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8-4-1886	9. AGE last birthday 63 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME DANIEL, HARVEY		14. MOTHER'S MAIDEN NAME SARAH HARVEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS MEMORIALHOSPITA, CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Embolism

631 × Antecedent cause(s) (b) Operation (uterine suspension & perineorrhaphy)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION June 14-50	19b. MAJOR FINDINGS OF OPERATION 3rd degree uterine prolapse	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/12, 1950, to 1/27, 1950, that I last saw the deceased alive on Jan 27, 1950, and that death occurred at 5:40 P m., from the causes and on the date stated above.

SIGNATURE W. A. Grain (Degree or title) ADDRESS Cumberland DATE SIGNED Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Jan 30, 1950	NAME OF CEMETERY OR CREMATORY White Church Cem.	LOCATION (City, town, or county) (State) Near Deer Park, Md.
DATE REC'D BY LOCAL REG. Jan. 30, 1950	REGISTRAR'S SIGNATURE Winter R. Krantz, M.D.	24. FUNERAL DIRECTOR H.C. Leighton, Oakland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00097

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westernport; MARYLAND; LENGTH OF STAY (In this place) 22 mos; HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD # 1, Box 54

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport rural; STREET ADDRESS (If rural, give location) 2 mi N of Westernport

3. NAME OF DECEASED (Type or Print): (First) BETTY (Middle) LOU (Last) WILT

4. DATE OF DEATH: (Month) Jan (Day) 9 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: April 22,48

9. AGE last birthday: 1 yrs. If under 1 year: Months 20, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Z. Wilt

14. MOTHER'S MAIDEN NAME: Lora A. Broadwater

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): - - - -

16. SOCIAL SECURITY No.: - - - - - - - - -

17. INFORMANT AND ADDRESS: William Z. Wilt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X **Immediate cause** (a) Lobar pneumonia — Interval Between Onset and Death: 4 days

Antecedent cause(s)

108 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) II Asthma, chr. bronchial

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-6, 1950, to 1-9, 1950, that I last saw the deceased alive on 1-9, 1950, and that death occurred at 5 30 P m., from the causes and on the date stated above.

SIGNATURE: James W Overton Jr (Degree or title) M.D. ADDRESS: Piedmont W. Va DATE SIGNED: 1-10-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Jan 12, 50 | NAME OF CEMETERY OR CREMATORY: Philos Cemetery | LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG.: 1/10/50 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: E S Boal | ADDRESS: Westernport, Md

KVX64

RECEIVED
JAN 11 1950
BUREAU V. S.

Dr. Enfield

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00098

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 18 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 742 N. MECHANIC STREET

3. NAME OF DECEASED (Type or Print)	(First) HAZEL	(Middle)	(Last) WINEBRENNER	4. DATE OF DEATH	(Month) JAN.	(Day) 20	(Year) 50
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 6/27/02	9. AGE last birthday: 47 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: Jacob Grady	14. MOTHER'S MAIDEN NAME: Martha Halderman						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Post operative Shock

171x

Antecedent cause(s)

48a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rectovaginal fistula

(c) Carcinoma of cervix

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Jan 20-50 — 19b. MAJOR FINDINGS OF OPERATION: Marked adhesions around bladder + sigmoid — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? Jan 2-50

22. I hereby certify that I attended the deceased from Jan 2, 1950, to Jan 20, 1950, that I last saw the deceased alive on Jan 20, 1950, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) ADDRESS: Cumberland — DATE SIGNED: Jan 22-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 1/23/1950 — NAME OF CEMETERY OR CREMATORY: Hill Crest — LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Jan. 23, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, MD — 24. FUNERAL DIRECTOR: Harvey H. Leigler — ADDRESS: Hyndman Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

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VS. A15

RECEIVED
JAN 31 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

00099

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1.1/2 hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt.Savage
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) Virgie (Last) Winebrenner

4. DATE OF DEATH (Month) Jan. (Day) 10 (Year) 1950

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH June 21-1907
9. AGE last birthday 42 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress
10b. KIND OF BUSINESS OR INDUSTRY Factory-Shirt
11. BIRTHPLACE (State or foreign country) Mt.Savage Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Henry Winebrenner
14. MOTHER'S MAIDEN NAME Annie Plummer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-09-4421
17. INFORMANT sister) Mrs. Henry Winebrenner, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure due to a	about 2 hours.
252.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) toxic goiter.	?
63b	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Jan.10-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Jan. 13 1950
NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist Cemetery
LOCATION (City, town, or county) Mt. Savage, (State) Md.

DATE REC'D BY LOCAL REG. Jan. 12, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer, ADDRESS Cumberland, Md.

49606

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

FBI
JAN 17 1950
BUREAU U. S.